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AETNA BETTER HEALTH® OF IOWA

Tab 1: Transmittal Letter and Bid Security Deposit

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AETNA BETTER HEALTH® OF IOWA

Transmittal Letter

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aetna®

Iowa Department of Human Services
Carrie Lindgren
Hoover Building, 1st Floor
1305 E. Walnut Street
Des Moines, Iowa 50319-0114

May 14, 2015

Pamela Sedmak

Chief Executive Officer
Aetna Medicaid
Phone: (602) 659-1160
E-mail: SedmakP@aetna.com

4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

AETNA BETTER HEALTH® OF IOWA

RE: Request for Proposal No. MED-16-009

Dear Ms. Lindgren:

Aetna Better Health of Iowa will furnish the services required by Members as promptly as is appropriate and that the services provided will meet the Agency's quality standards.

Aetna Better Health assures the capitation rates will cover all services required by Members and meet the Medical Loss Ratio requirements as listed in Attachment 1: Scope of Work, Section 2.7.

Aetna Better Health acknowledges that liquidated damages, as described in Exhibit E to Attachment 1: Scope of Work, may be imposed for failure to perform as set forth in this RFP.

Aetna Better Health acknowledges that the contract will be performance-based and both incentives and disincentives may apply to the Contractor's performance as set forth in this RFP.

Executive Summary

Today…*Katherine has health care coverage in Iowa, thanks to the Iowa Health and Wellness Plan.*

Katherine (not her real name) is a member of Coventry Health Care of Iowa's (CHC) Iowa Health and Wellness Plan. Coventry Health Care of Iowa is an affiliate of Aetna Better Health of Iowa Inc. (Aetna Better Health), the Bidder. Aetna Medicaid Administrators is an affiliate of both organizations and was instrumental in supporting Coventry Health Care to identify and address the challenges in the Iowa Health and Wellness Plan program, allowing Iowans like Katherine to continue to have coverage. CHC is the **sole remaining plan participating in the Iowa Health and Wellness Plan** created by Governor Branstad's vision to innovate and develop next-generation health care payment and delivery models. Through CHC, Katherine can get the services she needs to treat her diabetes and hypertension. She is enrolled in the Case Management program, where she receives education about her conditions and coordination of the services she needs to improve her health.

Do the Right Thing
for the Right Reason

Katherine has coverage today because CHC stood by her. CHC supported the Iowa Department of Human Services (the Agency), the Governor, and all Iowans in continuing to operate and support the Iowa Health and Wellness Plan program and its mission. When there were challenges, **CHC did not waver.** Instead, CHC and Aetna Medicaid (*Aetna Medicaid is comprised of Aetna Medicaid Administrators LLC, along with its affiliates that support the organization's Medicaid operations*) worked with DHS, the DOI, and the Governor's office to analyze the situation, find solutions, implement them, and carry on.

Tomorrow…

Aetna Better Health supports the Iowa High Quality Healthcare Initiative as the next step in the evolution of the Governor's vision to reform Medicaid and define the next generation of effective health care coverage and service delivery. **We will preserve and continue the legacy of service and commitment established by CHC by serving many more Iowans like Katherine.**

In this section, we discuss **how Aetna Better Health will serve Iowa and Iowans**, through people; strategies and approaches; along with systems and technology. We then show **why Aetna Better Health is the best choice to serve Iowa**, including history and experience, results, and our presence and commitment to the Iowa High Quality Healthcare Initiative, including the Iowa Health and Wellness Plan program.

The Aetna Medicaid Mission

Aetna's purpose is empowering people to live healthier lives. We achieve this by embedding our Company values of Integrity, Excellence, Caring and Inspiration into our culture and all that we do. At Aetna Medicaid, we believe in improving every life we touch as good stewards to those we serve, with Aetna's purpose and values as our foundation.

How We Will Serve Iowa and Iowans

By combining our people, effective strategies, programs, and processes, and technology, we can offer Iowa the best possible solution to meet the goals of the Iowa High Quality Healthcare Initiative (the Initiatives). Below, we highlight key elements of each.

People

Local Community-Based Plan - Iowans serving Iowans

An important distinction between Aetna Better Health and others: while the telephone and the Internet are useful tools, **there is no substitute for being there – in Iowa –** helping solve problems with the member, with the provider, and with the community. All of our member- and provider-facing staff will be in the local community. For this contract, based on our current enrollment projections, we will have more than 400 people in Iowa. **We will be hiring Iowans for these jobs.** Our Case Managers will be in the community, not in a call center. They go where they are needed, to see, support, and gain the trust of our members. Provider Services Representatives will make direct office visits in Iowa to educate, answer questions, and solve problems. Community Development Coordinators will create, coordinate, and produce educational appearances at local events, providing important health information for all Iowans who attend, not just Aetna Better Health members. Even Member Services Representatives who answer phones will be in Iowa offices, so they will speak from experience as they help beneficiaries address questions and access care. **We are not guessing what Iowa might be like; we know.**

The Living Wage

Listen, Respect, and Act with Insight, Understanding, Compassion

In January 2015, Aetna Chairman and CEO Mark Bertolini announced two new programs for Aetna employees that increase financial security for thousands of workers by improving wages and health care benefits. In April 2015, Aetna increased the minimum base hourly wage for its U.S. employees to $16 per hour. In 2016, Aetna will launch a voluntary, enhanced medical benefits program to help lower the out-of-pocket health care expenses for some of its U.S. employees. Savings to participating employees could be up to $4,000. **Both programs will be in effect for Aetna Better Health jobs in Iowa.**

Strategies, Programs, and Processes

While Aetna Better Health and Aetna Medicaid will use many strategies, programs, and processes to execute the contract, three will be critical to health care transformation in Iowa. These are the Integrated Care Management Program, our Value-Based Solutions, and what we will do to support the Initiatives. We describe these below.

Integrated Care Management

Pioneer in Fully Integrated Care

To deliver individually tailored service coordination and exceptional customer service to members, caregivers, and providers in our Iowa Long Term Services and Supports (LTSS) population, we will use the experience gained by Aetna Medicaid in more than 25 years of experience serving LTSS members in Arizona, Delaware, Florida, Illinois, Michigan, New Jersey, New York, and Ohio. In these, we have honed our approach to serving highly complex and frail populations with diverse benefits. We are equipped to successfully manage the varying benefits, cost shares, and eligibility requirements of the Iowa LTSS and Home and Community-Based Services (HCBS) waiver populations.

Our Integrated Care Management (ICM) program recognizes that every person is best cared for in a holistic manner. ICM integrates every aspect of care—physical, behavioral, and functional—in a unified team and set of processes. It does so under one roof; Aetna Better Health **does not outsource program components.** Physical and behavioral health clinicians, including Physicians, Registered Nurses, Advanced Practice Nurses, and Licensed Behavioral Health Specialists work face to face and side by side daily to identify members who have complex needs, assess and analyze their conditions, and coordinate with providers and community resources to deliver comprehensive health care and support.

ICM uses a disciplined methodology to identify our members who have the greatest biopsychosocial complexity; the ones who need the most care and support. Through our ICM program we:

- Engage members in defining their health goals, health care decisions, and care plans
- Remove or minimize the barriers that limit their ability to manage their own health and well-being
- Educate members about chronic disease self-management
- Help individuals remain in the least-restrictive, most-integrated environment based on their own preferences, needs, safety, burden of illness, and availability of family or other supports in a manner that is consistent with their personal and cultural values and beliefs

Our goal is to help members to develop resiliency and move toward self-direction and self-management of their conditions to achieve their optimal level of health and functioning.

Value-Based Solutions

Aetna Medicaid supports Governor Branstad's vision to innovate and develop next-generation health care payment and delivery models through Iowa's State Innovation Model (SIM) grant. Aetna has been involved with SIM grants and multi-payer demonstrations in various states including Arizona, Connecticut, Delaware, Maine, New York, Ohio, Pennsylvania, Maryland, Tennessee, and Utah. Aetna Medicaid health plans have been selected to participate in dual eligible programs in five markets: Arizona, Illinois, Michigan, New York, and Ohio.

Aetna has publicly committed that 75% of the company's network contracts will be tied to value-based arrangements by 2020. Aetna Better Health commits to having 50% of our Iowa members with providers who are under value-based arrangements by 2018, exceeding the RFP requirements.

Aetna Medicaid has created and implemented **value-based Purchasing (VBP) programs** that offer specific payment incentives for providers and systems to change their approach to care and thus reform the delivery system. Aetna Better Health will offer VBP programs to all eligible providers. The models:

- Share actionable data, combining claims and care management data and our industry leading risk stratification, predictive modeling, and population health management tools
- Assist providers with adopting expertise to move to progressive value-based payment models that start with Pay-for-Quality and can evolve to full risk
- Align resources to support local clinical collaboration and integration with our provider allies
- Focus on individualized, member-centered care management guided by Aetna Medicaid's integrated care and biopsychosocial model

To move to new payment models and gain expertise and competency with advanced population health management, providers at all capability levels must have an entry point to begin their transformation journey. From the earliest stages of their evolution, our VBP programs featured the patient-centered medical home (PCMH), ACA Section 2703 health homes, and pay-for-quality programs. These create a platform in which providers can learn and gain competencies that will enable them to move to more complex, risk-based arrangements. We believe that the entire provider continuum must have the opportunity to participate in our VBP models. In Iowa, we will involve the entire provider community.

Iowa Quality Initiatives

Our Quality Management/Quality Improvement program strategies will achieve meaningful, measurable improvements to help Iowa reach its quality goals. In this proposal, we describe:

- How we will **work with the Healthiest State Initiative** using strategies to address health risk factors, life expectancy and infant mortality, disease burden, and health infrastructure. Our tools include lifestyle change self-management resources; assessments of BMI and referral for nutritional counseling and weight management; better identification and enrollment of members in pregnancy case management; improving Care for Kids screening rates; and many others.
- How we will **work with the Mental Health and Disability Services redesign**, implementing various strategies to improve access, life in the community, person-centeredness, health and wellness, family and natural supports, and quality of life and safety. All of these are addressed directly within our ICM model, which views each person holistically and addresses their needs from a biopyschosocial perspective. Our strategies include improving behavioral and substance use disorders screening in primary care; using ICM to make care management more effective for individuals with mental health diagnoses and persons with disabilities; and supporting development of local systems of care for children with SED.

- How we will **complement Iowa's SAMHSA Substance Abuse Prevention and Treatment Block grant.** We will have initiatives to improve behavioral and substance use disorders screening. We will also use ICM and HCBS to make care management more effective for serious mental illnesses and co-occurring disorders as well as improve early identification of pregnant members with behavioral health or substance use disorders issues and enroll them into our Pregnancy Case Management program.

To incorporate the Value Index Score to drive transformation of the health care system, we will use our Value-Based Solution models that combine new payment and delivery models.

Technology

Quality and Value through Simple, Relevant Solutions

With the resources of Aetna Medicaid, Aetna Better Health will deliver a suite of technology tools—some used by members and providers and others used by health plan staff—that help directly support members and give providers and our staff the information they need to do the right thing at the right time for the member. More importantly, these technologies provide the information at the point of decision-making, supporting our stewardship role and our value for doing the right thing for the right reason, helping to achieve the program goals of quality and affordability. Four tools that members or providers will use directly include:

- **Member website** – The member website helps members get information when and where they need it. It is compatible with Section 508 of the Americans with Disabilities Act and is also optimized for use with mobile devices. Included are features such as provider search, Member Handbook, covered services and benefits, information on how to file complaints and appeals, community resources, information on Case Management, and how to contact us.
- **Aetna Better Health App** – Every member deserves to have the right information to make good decisions. To support this right, we will offer the free Aetna Better Health app for both iOS and Android smartphones. The mobile app will have several functions to make it easier for members to find information and coordinate their health care needs.
- **Provider portal** – Providers use the portal, which includes both public and protected sections, to access the provider manual, obtain program updates, enter or check the status of prior authorization requests, check member eligibility, list their panel members, find other Aetna Better Health participating providers for referrals, and check the status of claims they have filed.
- **Utilization Management Web Interface** – An integrated, secure web-based system will let providers submit all of the necessary information for an authorization request online. This comprehensive, rules-based utilization review and authorization system simplifies and automates the review process, providing timely responses to requests.

Four technology tools that are used by health plan staff include:

- **Care Management Information System** – A fully integrated information system for physical and behavioral health care management provides a complete suite of functional, physical, and behavioral health assessments, care planning tools, and monitoring functions. With this system, an Aetna Better Health Case Manager can develop a holistic picture of the member, create a care plan that meets the member's needs, goals, and desires, and follow up to evaluate a program's effectiveness and make appropriate changes when necessary. Through remote access capability, the

Case Manager can do this while face to face with the member in the field, allowing him or her to immediately answer questions, verify information, and take action.

- **Predictive Modeling** – Consolidated Outreach and Risk Evaluation (CORE) is Aetna Medicaid's proprietary, evidence-based, custom-developed tool for identifying members who will benefit most from our ICM program. CORE identifies members who are most at-risk and identifies members according to three high-risk groups: general high-risk, high-risk of an emergency department visit, and high-risk of an inpatient admission. CORE was developed specifically for use with the Medicaid population. A new capability added to CORE uses race and ethnicity factors to identify members who need outreach and management because of risk factors.
- **General Business Application System** – QNXT™ is our core operating platform. A set of 28 integrated system modules track eligibility, adjudicate claims, manage benefit packages, and support other general member and provider data management and reporting. While QNXT is in broad use across the industry, the original product was designed for the needs of Medicaid, and Aetna Medicaid configures and extends the system to support specific contract needs. EDM, the Encounter Data Management System, integrates with QNXT to manage the validation and submission of encounter data to the Agency.
- **Integrated Care Engine** – Aetna Medicaid has a dedicated data warehouse and analytics team. The warehouse—our Integrated Care Engine—aggregates data from many systems to provide reports and analytical capability to make better clinical and business decisions. It facilitates the predictive modeling capability of CORE. We designed this warehouse to meet the needs of Medicaid and can easily meet new needs as they arise; for example, integrating lab or radiology data. Using the Integrated Care Engine, our management team has the information to make effective decisions and to help DHS analyze program design changes when necessary.

Our proposal includes more information on these solutions and others; we will use them to help achieve the State's goals to improve the quality of care and health outcomes while leveraging the strength and success of current DHS initiatives.

Aetna Better Health will apply the same data warehouse and advanced expertise in analytics that Aetna Medicaid used to help Coventry Health Care and DHS to find a way to preserve the Iowa Health and Wellness Plan program.

Health Information Exchange

The Iowa Health Information Network (IHIN) will have a major role in our overall Population Health Management strategy. By combining information from Admission, Discharge, and Transfer (ADT) documents and other clinical data on the IHIN with Aetna Better Health internal data and clinical workflow, we can make a profound impact on reducing hospital readmissions and Emergency Department (ED) utilizations, thus improving the health of our members. Aetna has a long history of integration with Health Information Exchange platforms and fully understands the technology, processes, and requirements. We understand that this will be an evolutionary process. For example, we may need to begin with secure messaging, then connect directly with the five major health systems in the State for nightly ADT exchange, then add real-time ADT exchange with the IHIN.

Our Community Provider Interface, as part of our Integrated Care Technology Platform, will fully complement IHIN. While IHIN provides meaningful data to health care providers, integration of IHIN with our systems and processes transforms data into actions with measurable outcomes. We will:

- Provide resources and expertise to facilitate integration with Aetna Medicaid systems.
- Use the Community Provider Interface to help Aetna Better Health providers in the state to access select care management data in combination with data from the IHIN. This will be a significant incentive for providers to join our network.

- Demonstrate the benefits of integrated model of care management with IHIN to facilitate communication, collaboration, and information sharing among stakeholders.
- Train providers and care team members on how to use Aetna Medicaid tools and applications.

Our mission and tools combined with IHIN capabilities will help providers and members produce quality outcomes. Providers who are connected can use our infrastructure for all of our members; our approach can communicate with other electronic health record systems and is not system-specific. There will be no cost to providers for joining the program.

Why Aetna Better Health is the Right Choice for Iowa

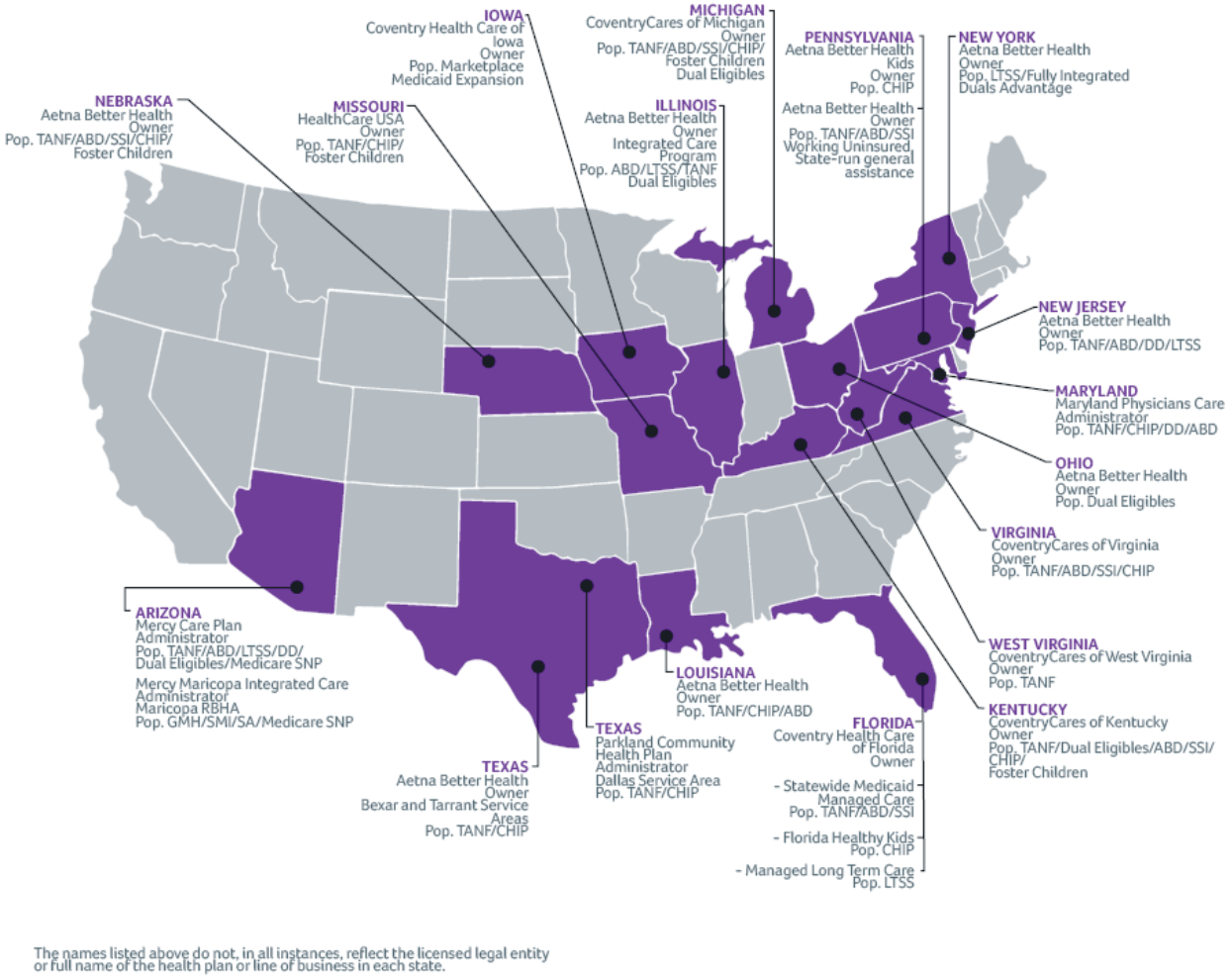
Aetna Better Health is the right choice because of our history and experience, the results we have delivered for similar programs, and our presence in and commitment to Iowa. We highlight each below.

History and Experience

Aetna Better Health and Aetna Medicaid

Aetna Better Health will leverage the experience of Aetna Medicaid, a **leader in Medicaid managed care since 1986 that currently serves nearly 3 million members in 17 states.** With nearly 4,000 employees and over 1,000 more in dedicated claims, information technology, finance, actuarial, and other roles, Aetna Medicaid has the experience, resources, and infrastructure to support Aetna Better Health in Iowa. Figure TL-1 provides a geographic overview of Aetna's Medicaid experience.

Figure TL-1: Aetna Medicaid map



In 2007, Aetna acquired Schaller Anderson, Inc., a privately-held Medicaid managed care company that was founded in 1986. Founders Don Schaller and Joe Anderson had been the director and deputy director of the Arizona Medicaid program in 1981, at the time of its creation as the first fully-capitated statewide managed care program in the nation. This success was followed by the creation of the Arizona Long-Term Care System (ALTCS) in 1989, which was the first statewide fully-capitated managed care program for individuals eligible for institutional care. Throughout that decade and those that followed, Schaller Anderson remained at the forefront of innovation in Medicaid managed care as states across the nation emulated Arizona's success. Aetna Medicaid has built upon this foundation as it has expanded its reach across the nation. Both Aetna Better Health and Aetna Medicaid will leverage the resources and infrastructure of their 160-year-old parent company, Aetna, Inc.

Three Decades of Caring for Those Most Vulnerable

Aetna Medicaid has **30 years of experience** in managing the care of the most vulnerable, using innovative approaches to achieve successful health care results and favorable cost outcomes. Aetna Medicaid has particular expertise serving high-need Medicaid members, including over 190,000 ABD members; over 37,000 in dual eligible programs and nearly 11,000 duals where we cover only the Medicaid benefit; nearly 25,000 in specific LTSS programs; nearly 19,000 SMI members; and over 10,000 members in Intellectual / Developmental

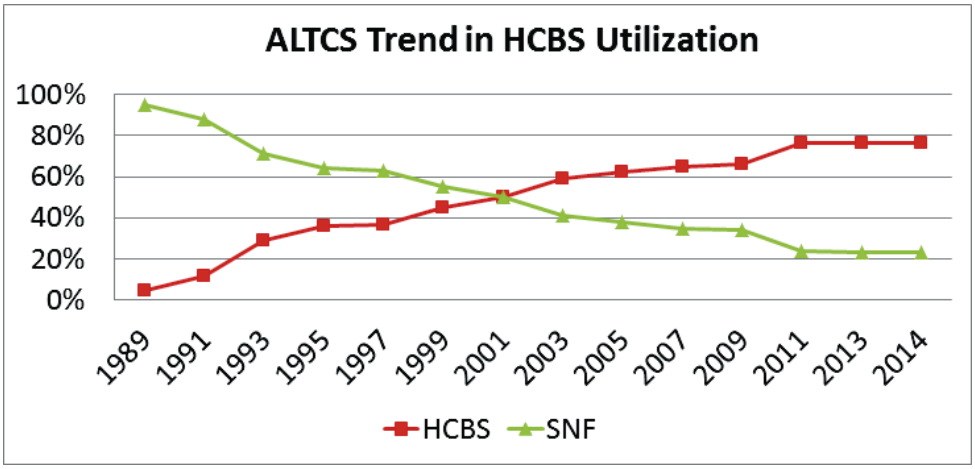
Disability or DD programs. Our experiences, and the services we offer, are consistent with the scope of services the Agency is asking us to perform.

Results For Similar Programs

Our LTSS and HCBS programs focus on helping the member live successfully in the community based on the member's choice. As Figure TL-2 shows, our results show the impact of managed care in diverting members to community-based services. Aetna Medicaid helped the state of Arizona achieve a dramatic improvement of the HCBS Ratio in the LTSS program.

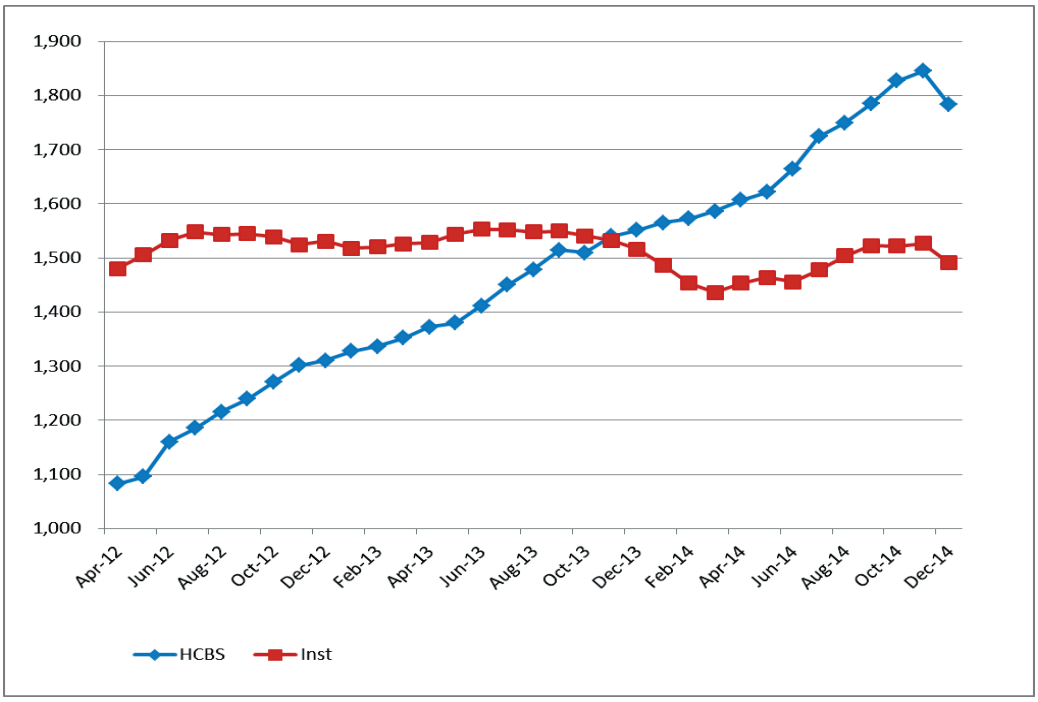
- From 1993 - 2002, the ratio improved by an average 3% per year
- From 2003 - 2008, the ratio improved by an average 2% per year
- From 2009 - 2014, the ratio improved by an average 1.2% per year

Figure TL-2: HCBS Ratio Improvement in AZ: 1993 - 2014



Our results in Delaware, shown in Figure TL-3 below, show our ability to increase use of home- and community-based services while decreasing use of institutional facilities. **The plan successfully improved the HCBS ratio by approximately 7% over two years.**

Figure TL-3: Delaware LTSS rebalancing since program start in 2012



Our Value

Independent Analysis: **A 2012 analysis by Avalere Health showed that members in a plan managed by Aetna Medicaid in Arizona, after adjustment for risk, made higher use of preventive/ambulatory services and had lower rates of inpatient utilization, emergency department utilization, and all-cause readmissions relative to patterns of care for dual eligibles enrolled in Original Medicare (FFS). When compared to the total national FFS dual eligibles, and adjusted to match the risk of the FFS dual eligibles, the member population exhibited:**

- **3% higher proportion of beneficiaries accessing preventive/ambulatory health services**
- **31% lower discharge rate (as a measure of inpatient utilization)**
- **43% lower rate of days spent in the hospital (as a measure of inpatient utilization)**
- **19% lower average length of stay (as a measure of inpatient utilization)**
- **9% lower rate of ED visits**
- **21% lower readmission rate**

Presence in and Commitment to Iowa

Stability, Competency, and Trust in the Face of Challenge

Our parent organization, Aetna Inc., has been operating in Iowa since 1985, and our commercial and Medicare plan in Iowa today serves over 178,000 members including over 10,000 members who are eligible for Medicaid. Our existing commercial and Medicare network in Iowa has 20,304 physicians (Primary Care Providers and specialists) and over 4,000 facilities (hospitals, ambulatory surgical centers, skilled nursing facilities, radiology centers, etc.). We are not new to the state; rather, we have institutional knowledge about Iowa that we will leverage as we create our provider network for the State. Because of Aetna Medicaid's decades of experience in contracting provider networks in rural areas, we understand the access challenges facing Iowa.

Explore Ideas to Make the World a Better Place

We will complement our Iowa provider network with relationships with community organizations, agencies, and faith-based services throughout the State. During our development work, we have traveled throughout Iowa to have conversations with providers and community organizations about what is most needed to serve members. A particular emphasis will be to minimize administrative burden to allow providers to focus on serving members.

Through our relationships with existing Aetna Medicaid plans in Iowa's border states of Missouri, Nebraska, and Illinois and the provider networks they have in place, we strengthen our resource base for Iowa operations. See Figure TL-4.

Figure TL-4: Plans in neighboring states will provide network relationships to serve Iowa

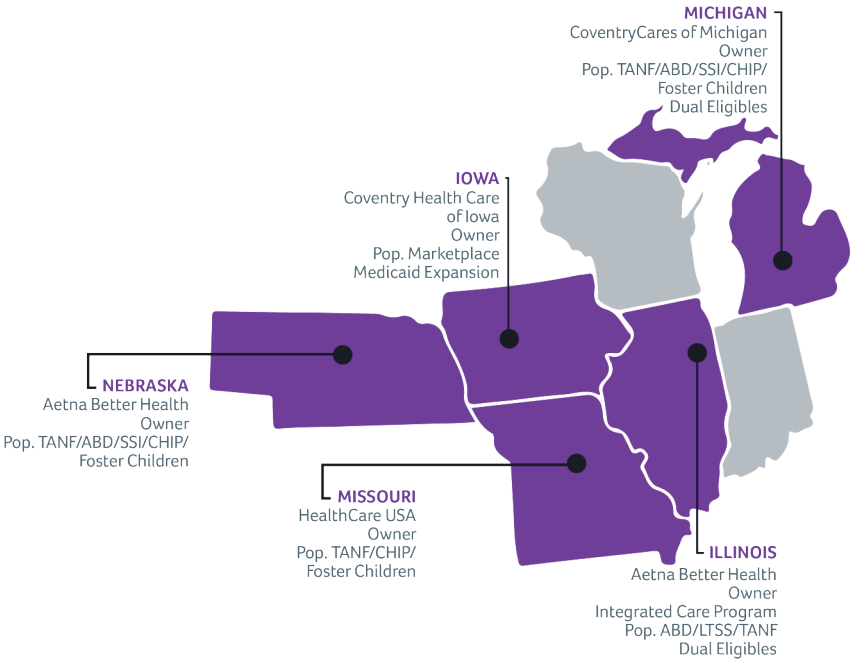


Figure TL-5 (also provided in Section 2, Question 2.11, Question 1 in larger format) shows many of of the providers and organizations with whom we have had discussions; we will continue to work with these as we implement and operate the contract.

Figure TL-5: [redacted]

CONFIDENTIAL

[redacted]

As we crisscrossed the State, introducing ourselves, sharing our philosophy and listening to issues and concerns about managed care, we made a deliberate decision not to ask for letters of support from people we had just met. Even though these letters were often offered and, in some cases, sent to our corporate headquarters unsolicited, we chose not to include them in this proposal. Why? Because we believe that trust is something that is earned through action and over time. We are confident we will earn the trust and support of Iowa providers and stakeholders but we also know that it takes more than asking for a signed letter to do so. The map above (Figure TL-5) tells the Aetna Medicaid story of the actual time and resources we have only just begun to commit to the State of Iowa and that will evolve throughout the lifecycle of our managed care contract.

Even more important is our commitment and persistence to making programs work effectively to serve members and doing the right thing no matter where we are. In the following sections, we talk about how we helped preserve the Iowa Health and Wellness Plan vision and how we rose to the challenge in Kentucky when another Medicaid managed care plan suddenly exited the program.

Preserving the Iowa Health and Wellness Plan Vision

BIRTH OF IOWA HEALTH AND WELLNESS PLAN

The Iowa Health and Wellness Plan was Governor Branstad's signature health care program; Iowa would be one of the first states to pursue Medicaid expansion under a private option. Iowa Health and Wellness Plan was quickly approved by the legislature and Centers for Medicare and Medicaid Services (CMS), allowing the State to recruit insurers to participate in Iowa Health and Wellness Plan. The Iowa Medicaid program would subsidize those members purchasing Iowa Health and Wellness Plan coverage on the exchange through the Marketplace Choice Plan. Larger insurers in the state chose not to participate. Coventry Health Care (CHC) chose to participate, as did Co-Opportunity Health (the Co-Op), the nonprofit cooperative funded under the Affordable Care Act.

CHALLENGES TO SUCCESS

The program began in January 2014. Despite strong enrollment and a smooth start, it quickly became apparent that premiums were not covering actual costs. The Co-Op faced the same challenges. In September 2014, the Co-Op notified the Agency that it would be exiting Iowa Health and Wellness Plan. The State moved the Co-Op members to the fee-for-service Wellness Plan. Soon, the Co-Op was placed into receivership, as the unpaid claims on their books exceeded their available funds.

WORKING TOGETHER TO CREATE A SOLUTION FOR IOWA

In January 2015, Aetna leaders and I met with the governor's office, state policy leaders, and representatives from the Agency and the Iowa Insurance Division to brainstorm how we could save the Iowa Health and Wellness Program. Working together, we came up with a solution that could be achieved quickly.

The entire group held a working meeting to create a plan to preserve Iowa Health and Wellness Plan. Aetna Medicaid's Informatics, Actuarial, and Medical Management teams developed an analytical methodology to identify Iowa Health and Wellness Plan members who were medically frail or at high-risk. We then contacted those members and transferred them to the Medicaid fee for service program, as medically frail members were better served by that program. Simultaneously, Iowa officials filed a request with CMS for an emergency rate increase and permission to cap Coventry's enrollment. These actions made the program financially viable and made it possible to continue coverage for Iowa Health and Wellness Plan members, including Katherine, through the end of 2015.

A WIN-WIN SOLUTION

It took incredible collaboration with the State and the Aetna Medicaid team, and resulted in a win-win for the state, the taxpayers, the members, and for us. We are proud to be part of the solution for this program. **The same dedicated executives that were part of the solution for Iowa Health and Wellness Plan will deliver on the promise of transformation for the Iowa High Quality Healthcare Initiative.**

Rising to the challenge in Kentucky

We have a reputation for persisting through difficulties that have made others walk away. When a Medicaid managed care contractor terminated its contract on short notice with the Commonwealth of Kentucky effective Friday July 5, 2013 at 11:59 p.m., we rose to the challenge of bringing 68,000 of the outgoing health plan's Medicaid members on board immediately. We received the eligibility file mid-morning the next day. These members had no idea they had been transitioned to a new health plan overnight. We worked hard to make it a seamless transition for providers and new members while continuing to provide the best service for our existing 200,000 members. Despite the challenges, we were able to meet the needs of our new membership.

The results at the end of the transition were significant. We completed 1,100 case management contacts, which allowed us to:

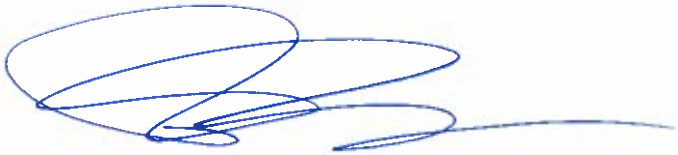
- Identify 83 members who were high-risk obstetrical patients
- Contact all new organ transplant members and begin full medical reviews for each member
- Manage 50 behavioral health transitions-of-care; contacted affected members to identify care needs

Additionally, our Member Services staff continued to experience an influx of calls from new members and achieved the highest service levels and the best average speed-to-answer rates, maintaining call-service levels at close to 99% with an average abandonment rate of less than 1%.

LOOKING AHEAD

We are proud of the different ways we have risen to the challenge, assisting state Medicaid agencies in finding solutions to significant challenges facing their programs. We welcome the opportunity for continued collaboration with the Agency to make the Iowa High Quality Healthcare Initiative successful for all stakeholders. We are committed to serving you, Iowa providers, and especially people like Katherine, who are counting on us to be there when they need us.

Respectfully,



Pamela Sedmak
Chief Executive Officer
Aetna Medicaid

AETNA BETTER HEALTH® OF IOWA

Bid Security Deposit

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BID BOND

TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA
Hartford, Connecticut 06183

KNOW ALL MEN BY THESE PRESENTS,

That we, **Aetna Better Health of Iowa Inc.** as Principal, hereinafter called the Principal, and TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA, of Hartford, Connecticut, a corporation duly organized under the laws of the State of Connecticut, as Surety, hereinafter called the Surety, are held and firmly bound unto **Iowa Department of Human Services** as Obligee, hereinafter called the Obligee, in the sum of **One Hundred Thousand Dollars and 00/100 Cents ($100,000.00)** for the payment of which sum well and truly to be made, the said Principal and the said Surety, bind ourselves, our heirs, executors, administrators, successors and assigns, jointly and severally, firmly by these presents.

WHEREAS, the Principal has submitted a bid for **Iowa High Quality Healthcare Initiative RFP# MED-16-009**

NOW, THEREFORE, if the Obligee shall accept the bid of the Principal and the Principal shall enter into a Contract with the Obligee in accordance with the terms of such bid, and give such bond or bonds as may be specified in the bidding or Contract Documents with good and sufficient surety for the faithful performance of such Contract and for the prompt payment of labor and material furnished in the prosecution thereof, or in the event of the failure of the Principal to enter such Contract and give such bond or bonds, if the Principal shall pay to the Obligee the difference not to exceed the penalty hereof between the amount specified in said bid and such larger amount for which the Obligee may in good faith contract with another party to perform the Work covered by said bid, then this obligation shall be null and void, otherwise to remain in full force and effect.

Signed and sealed this **20th** day of **March, 2015.**

Laurie J Mara
(Witness)

Aetna Better Health of Iowa Inc.
(Principal) (Seal)

(Title)

Amanda Kutzlomey
(Witness)

TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA

By Kristin Philipp
Kristin Philipp, (Attorney-in-Fact)

S-1869-G (07-97)

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TRAVELERS

POWER OF ATTORNEY

Farmington Casualty Company
Fidelity and Guaranty Insurance Company
Fidelity and Guaranty Insurance Underwriters, Inc.
St. Paul Fire and Marine Insurance Company
St. Paul Guardian Insurance Company

St. Paul Mercury Insurance Company
Travelers Casualty and Surety Company
Travelers Casualty and Surety Company of America
United States Fidelity and Guaranty Company

Attorney-In Fact No. 227697

Certificate No. 005914579

KNOW ALL MEN BY THESE PRESENTS: That Farmington Casualty Company, St. Paul Fire and Marine Insurance Company, St. Paul Guardian Insurance Company, St. Paul Mercury Insurance Company, Travelers Casualty and Surety Company, Travelers Casualty and Surety Company of America, and United States Fidelity and Guaranty Company are corporations duly organized under the laws of the State of Connecticut, that Fidelity and Guaranty Insurance Company is a corporation duly organized under the laws of the State of Iowa, and that Fidelity and Guaranty Insurance Underwriters, Inc., is a corporation duly organized under the laws of the State of Wisconsin (herein collectively called the "Companies"), and that the Companies do hereby make, constitute and appoint

Jeffrey M. Johnson, Cameron W. Blackey, Daniel T. Boermeester, Matthew Kieras, Mary N. Smith, Helen B. Honan, Sarah Marks, Thomas J. McElligott, Kevin J. Mulrey, Karen L. Nigrelli, Kristin Philipp, Eric Pratt, Diane Vardaro, Christopher J. Ward, Patricia A. Wood, Thomas E. Young, Katherine K. Zalios-Wood, Anne Pandolfe, Jamie L. Damiano, Tiffany York, Amy Reese, Justine M. Parsloe, Daniel Peck, Amanda Bartolomei, Danielle Schiller, and Ryan Allison

of the City of Braintree, State of Massachusetts, their true and lawful Attorney(s)-in-Fact, each in their separate capacity if more than one is named above, to sign, execute, seal and acknowledge any and all bonds, recognizances, conditional undertakings and other writings obligatory in the nature thereof on behalf of the Companies in their business of guaranteeing the fidelity of persons, guaranteeing the performance of contracts and executing or guaranteeing bonds and undertakings required or permitted in any actions or proceedings allowed by law.

WARNING: THIS POWER OF ATTORNEY IS INVALID WITHOUT THE RED BORDER

IN WITNESS WHEREOF, the Companies have caused this instrument to be signed and their corporate seals to be hereto affixed, this 23rd day of May, 2014.

Farmington Casualty Company
Fidelity and Guaranty Insurance Company
Fidelity and Guaranty Insurance Underwriters, Inc.
St. Paul Fire and Marine Insurance Company
St. Paul Guardian Insurance Company

St. Paul Mercury Insurance Company
Travelers Casualty and Surety Company
Travelers Casualty and Surety Company of America
United States Fidelity and Guaranty Company

State of Connecticut
City of Hartford ss.

By: _____
Robert L. Raney, Senior Vice President

On this the 23rd day of May, 2014, before me personally appeared Robert L. Raney, who acknowledged himself to be the Senior Vice President of Farmington Casualty Company, Fidelity and Guaranty Insurance Company, Fidelity and Guaranty Insurance Underwriters, Inc., St. Paul Fire and Marine Insurance Company, St. Paul Guardian Insurance Company, St. Paul Mercury Insurance Company, Travelers Casualty and Surety Company, Travelers Casualty and Surety Company of America, and United States Fidelity and Guaranty Company, and that he, as such, being authorized so to do, executed the foregoing instrument for the purposes therein contained by signing on behalf of the corporations by himself as a duly authorized officer.

In Witness Whereof, I hereunto set my hand and official seal.
My Commission expires the 30th day of June, 2016.

Marie C. Tetreault, Notary Public

58440-8-12 Printed in U.S.A.

This Power of Attorney is granted under and by the authority of the following resolutions adopted by the Boards of Directors of Farmington Casualty Company, Fidelity and Guaranty Insurance Company, Fidelity and Guaranty Insurance Underwriters, Inc., St. Paul Fire and Marine Insurance Company, St. Paul Guardian Insurance Company, St. Paul Mercury Insurance Company, Travelers Casualty and Surety Company, Travelers Casualty and Surety Company of America, and United States Fidelity and Guaranty Company, which resolutions are now in full force and effect, reading as follows:

RESOLVED, that the Chairman, the President, any Vice Chairman, any Executive Vice President, any Senior Vice President, any Vice President, any Second Vice President, the Treasurer, any Assistant Treasurer, the Corporate Secretary or any Assistant Secretary may appoint Attorneys-in-Fact and Agents to act for and on behalf of the Company and may give such appointee such authority as his or her certificate of authority may prescribe to sign with the Company's name and seal with the Company's seal bonds, recognizances, contracts of indemnity, and other writings obligatory in the nature of a bond, recognizance, or conditional undertaking, and any of said officers or the Board of Directors at any time may remove any such appointee and revoke the power given him or her; and it is

FURTHER RESOLVED, that the Chairman, the President, any Vice Chairman, any Executive Vice President, any Senior Vice President or any Vice President may delegate all or any part of the foregoing authority to one or more officers or employees of this Company, provided that each such delegation is in writing and a copy thereof is filed in the office of the Secretary; and it is

FURTHER RESOLVED, that any bond, recognizance, contract of indemnity, or writing obligatory in the nature of a bond, recognizance, or conditional undertaking shall be valid and binding upon the Company when (a) signed by the President, any Vice Chairman, any Executive Vice President, any Senior Vice President or any Vice President, any Second Vice President, the Treasurer, any Assistant Treasurer, the Corporate Secretary or any Assistant Secretary and duly attested and sealed with the Company's seal by a Secretary or Assistant Secretary; or (b) duly executed (under seal, if required) by one or more Attorneys-in-Fact and Agents pursuant to the power prescribed in his or her certificate or their certificates of authority or by one or more Company officers pursuant to a written delegation of authority; and it is

FURTHER RESOLVED, that the signature of each of the following officers: President, any Executive Vice President, any Senior Vice President, any Vice President, any Assistant Vice President, any Secretary, any Assistant Secretary, and the seal of the Company may be affixed by facsimile to any Power of Attorney or to any certificate relating thereto appointing Resident Vice Presidents, Resident Assistant Secretaries or Attorneys-in-Fact for purposes only of executing and attesting bonds and undertakings and other writings obligatory in the nature thereof, and any such Power of Attorney or certificate bearing such facsimile signature or facsimile seal shall be valid and binding upon the Company and any such power so executed and certified by such facsimile signature and facsimile seal shall be valid and binding on the Company in the future with respect to any bond or understanding to which it is attached.

I, Kevin E. Hughes, the undersigned, Assistant Secretary, of Farmington Casualty Company, Fidelity and Guaranty Insurance Company, Fidelity and Guaranty Insurance Underwriters, Inc., St. Paul Fire and Marine Insurance Company, St. Paul Guardian Insurance Company, St. Paul Mercury Insurance Company, Travelers Casualty and Surety Company, Travelers Casualty and Surety Company of America, and United States Fidelity and Guaranty Company do hereby certify that the above and foregoing is a true and correct copy of the Power of Attorney executed by said Companies, which is in full force and effect and has not been revoked.

WARNING: THIS POWER OF ATTORNEY IS INVALID WITHOUT THE RED BORDER

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the seals of said Companies this 20th day of March, 2015.

Kevin E. Hughes, Assistant Secretary

To verify the authenticity of this Power of Attorney, call 1-800-421-3880 or contact us at www.travelersbond.com. Please refer to the Attorney-In-Fact number, the above-named individuals and the details of the bond to which the power is attached.

TRAVELERS

One Tower Square
Mail Drop - S102A
Hartford, CT 06183

Meghan Towers
Counsel*
Bond & Specialty Insurance
Phone: (860) 954-6497
Fax: (888) 201-5608
Email: mtowers2@travelers.com

March 23, 2015

Aetna, Inc.
Attn: Sherry Albee
151 Farmington Avenue, RE2T
Hartford, CT 06156

Re: License To Do Business

Dear Ms. Albee:

This letter confirms that as of the date of this letter Travelers Casualty and Surety Company of America is licensed to do business in all fifty states of the United States of America, including Iowa, as well as the District of Columbia, Guam, Puerto Rico and the Virgin Islands.

If you have any questions or require any additional information regarding this topic please do not hesitate to contact me.

Best,

Meghan Towers

* Licensed in New York; Connecticut Authorized House Counsel

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Aetna Parent Guarantee

151 Farmington Avenue
Hartford, CT 06156

David Buda
Vice President, Finance
and Treasurer
860-273-5664
BudaD@aetna.com

April 29, 2015

Iowa Insurance Division
Tow Ruan Center
601 Locust Street – 4th Floor
Des Moines, IA 50309-3738

Subject: Minimum Capital Support for Aetna Better Health of Iowa Inc.

Dear Sir or Madam:

Aetna Inc. ("Aetna") is a publicly traded company and is the ultimate parent entity of Aetna Better Health of Iowa Inc. ("ABH IA"). This letter from Aetna is given solely to satisfy requirements set forth in Section 191:40.12(3) of the Iowa Administrative Code.

Aetna will provide the necessary capital support to ABH IA in order for ABH IA to meet the minimum capital and RBC requirements prescribed by the State of Iowa during the term of the Medicaid contract awarded to ABH IA.

Acknowledged and agreed by:

Aetna Inc.

By:_____
Name: David Buda
Title: Vice President, Finance and Treasurer

AETNA BETTER HEALTH® OF IOWA

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AETNA BETTER HEALTH® OF IOWA

Tab 3: Bidder's Approach to Meeting the Scope of Work

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AETNA BETTER HEALTH® OF IOWA

Section 1: RFP Purpose and Background

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SECTION 1 – RFP PURPOSE AND BACKGROUND

Below is a table that outlines how the Scope of Work provided in RFP Attachment 1 relates to the responses to the questions provided in RFP Attachment 5. We provide this table to reduce redundancy of responses and information and to simplify the evaluation process for the evaluators.

For requirements in Attachment 1 that do not require a detailed response, the table below indicates our intent to comply with the stated requirement.

Attachment 1 Requirement	Cross Reference to Attachment 5	Will Comply
1.1 Purpose	--	Yes
1.2 Goals	--	Yes
1.3 Reserved	--	Yes
1.4 General Contractor Responsibilities	1.4.1	Yes
1.4.1 Federal and State Laws and Regulations	1.4.1	Yes
1.4.2 Qualifications	1.4.2	Yes
1.4.2.1	1.4.2	Yes
1.4.2.2	1.4.2	Yes
1.4.2.3	1.4.2	Yes
1.4.2.4	1.4.2	Yes
1.4.2.5	1.4.2	Yes
1.4.2.6	1.4.2	Yes
1.4.2.7	1.4.2	Yes
1.4.2.8	1.4.2	Yes
1.4.2.9	1.4.2	Yes
1.4.2.10	1.4.2	Yes
1.4.2.11	1.4.2	Yes
1.5 Effects of the Federal Waiver	--	Yes

Please explain how you propose to execute Section 1 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience. To the extent that a more detailed description of your qualifications and relevant experience for this section is described in more detail later in your proposal, a brief summary will suffice.

Please see our response to Section 1.4, Question 2 for a brief explanation of how we propose to execute Section 1 as well as a description of our relevant experience and qualifications.

1.4 General Contractor Responsibilities

Attachment 5 – Section 1.4, Question 1 [SOW 1.4.1]

1. Indicate your ability to comply with all Federal and State Laws and Regulations that may affect this Contract.

Aetna Better Health is able to comply with all Federal and State Law and Regulations that may affect this Contract.

Attachment 5 – Section 1.4, Question 2 [SOW 1.4.2]

2. Summarize how you are qualified to provide the services listed in Section 1.4.2.

Today…*Katherine has health care coverage in Iowa, thanks to Iowa Health and Wellness Plan.*

Katherine (not her real name) is a member of Coventry Health Care of Iowa's (CHC) Iowa Health and Wellness Plan. Coventry Health Care of Iowa is an affiliate of Aetna Better Health of Iowa Inc. (Aetna Better Health), the Bidder. Aetna Medicaid Administrators is an affiliate of both organizations and was instrumental in supporting Coventry Health Care to identify and address the challenges in the Iowa Health and Wellness Plan program, allowing Iowans like Katherine to continue to have coverage. CHC is the **sole remaining plan participating in the Iowa Health and Wellness Plan** created by Governor Branstad's vision to innovate and develop next-generation health care payment and delivery models. Through CHC, Katherine can get the services she needs to treat her diabetes and hypertension. She is enrolled in the Case Management program, where she receives education about her conditions and coordination of the services she needs to improve her health.

Do the Right Thing
for the Right Reason

Katherine has coverage today because CHC stood by her. CHC supported Iowa Department of Human Services (the Agency), the Governor, and all Iowans in continuing to operate and support the Iowa Health and Wellness Plan program and its mission. When there were challenges, **CHC did not waver.** Instead, CHC and Aetna Medicaid (*Aetna Medicaid is comprised of Aetna Medicaid Administrators LLC, along with its affiliates that support the organization's Medicaid operations*) worked with DHS, the DOI, and the Governor's office to analyze the situation, find solutions, implement them, and carry on.

Tomorrow…

Aetna Better Health supports the Iowa High Quality Healthcare Initiative as the next step in the evolution of the Governor's vision to reform Medicaid and define the next generation of effective health care coverage and service delivery. **We will preserve and continue the legacy of service and commitment established by CHC by serving many more Iowans like Katherine.**

In this section, we discuss **how Aetna Better Health will serve Iowa and Iowans**, through people; strategies and approaches; and systems and technology. We then show **why Aetna Better Health is the best choice to serve Iowa**, including history and experience, results, and our presence and commitment to Iowa health care, including the Iowa Health and Wellness Plan program.

The Aetna Medicaid Mission

Aetna's purpose is empowering people to live healthier lives. We achieve this by embedding our Company values of Integrity, Excellence, Caring and Inspiration into our culture and all that we do. At Aetna Medicaid, we believe in improving every life we touch as good stewards to those we serve, with Aetna's purpose and values as our foundation.

How We Will Serve Iowa and Iowans

By combining our people, effective strategies, programs, and processes, and technology, we can offer Iowa the best possible solution to meet the goals of the Iowa High Quality Healthcare Initiative (the Initiatives). Below, we highlight key elements of each.

People

Local Community-Based Plan - Iowans serving Iowans

An important distinction between Aetna Better Health and others: while the telephone and the Internet are useful tools, **there is no substitute for being there – in Iowa** – helping solve problems with the member, with the provider, and with the community. All of our member- and provider-facing staff will be in the local community. For this contract, based on our current enrollment projections, we will have more than 400 people in Iowa. **We will be hiring Iowans for these jobs.** Our Case Managers will be in the community, not in a call center. They go where they are needed, to see, support, and gain the trust of our members. Provider Services Representatives will make direct office visits in Iowa to educate, answer questions, and solve problems. Community Development Coordinators will create, coordinate, and produce educational appearances at local events, providing important health information for all Iowans who attend, not just Aetna Better Health members. Even Member Services Representatives who answer phones will be in Iowa offices, so they will speak from experience as they help beneficiaries address questions and access care. **We are not guessing what Iowa might be like; we know.**

Listen, Respect, and Act with Insight, Understanding, Compassion

The Living Wage

In January 2015, Aetna Chairman and CEO Mark Bertolini announced two new programs for Aetna employees that increase financial security for thousands of workers by improving wages and health care benefits. In April 2015, Aetna increased the minimum base hourly wage for its U.S. employees to $16 per hour. In 2016, Aetna will launch a voluntary, enhanced medical benefits program to help lower the out-of-pocket health care expenses for some of its U.S. employees. Savings to participating employees could be up to $4,000. **Both programs will be in effect for Aetna Better Health jobs in Iowa.**

Strategies, Programs, and Processes

While Aetna Better Health and Aetna Medicaid will use many strategies, programs, and processes to execute the contract, three will be critical to health care transformation in Iowa. These are the Integrated Care Management Program, our Value-Based Solutions, and what we will do to support the Initiatives. We describe these below.

Integrated Care Management

Pioneer in Fully Integrated Care

To deliver individually tailored service coordination and exceptional customer service to members, caregivers, and providers in our Iowa Long Term Services and Supports (LTSS) population, we will use the experience gained by Aetna Medicaid in more than 25 years of experience serving LTSS members in Arizona, Delaware, Florida, Illinois, Michigan, New Jersey, New York, and Ohio. In these, we have honed our approach to serving highly complex and frail populations with diverse benefits. We are equipped to successfully manage the varying benefits, cost shares, and eligibility requirements of the Iowa LTSS and Home and Community-Based Services (HCBS) waiver populations.

Our Integrated Care Management (ICM) program recognizes that every person is best cared for in a holistic manner. ICM integrates every aspect of care—physical, behavioral, and functional—in a unified team and set of processes. It does so under one roof; Aetna Better Health **does not outsource program components.** Physical and behavioral health clinicians, including Physicians, Registered Nurses, Advanced Practice Nurses, and Licensed Behavioral Health Specialists work face to face and side by side daily to identify members who have complex needs, assess and analyze their conditions, and coordinate with providers and community resources to deliver comprehensive health care and support.

ICM uses a disciplined methodology to identify our members who have the greatest biopsychosocial complexity; the ones who need the most care and support. Through our ICM program we:

- Engage members in defining their health goals, health care decisions, and care plans
- Remove or minimize the barriers that limit their ability to manage their own health and well-being
- Educate members about chronic disease self-management
- Help individuals remain in the least-restrictive, most-integrated environment based on their own preferences, needs, safety, burden of illness, and availability of family or other supports in a manner that is consistent with their personal and cultural values and beliefs

Our goal is to help members to develop resiliency and move toward self-direction and self-management of their conditions to achieve their optimal level of health and functioning.

Value-Based Solutions

Aetna Medicaid supports Governor Branstad's vision to innovate and develop next-generation health care payment and delivery models through Iowa's State Innovation Model (SIM) grant. Aetna has been involved with SIM grants and multi-payer demonstrations in various states including Arizona, Connecticut, Delaware, Maine, New York, Ohio, Pennsylvania, Maryland, Tennessee, and Utah. Aetna Medicaid health plans have been selected to participate in dual eligible programs in five markets: Arizona, Illinois, Michigan, New York, and Ohio.

Aetna has publicly committed that 75% of the company's network contracts will be tied to value-based arrangements by 2020. Aetna Better Health commits to having 50% of our Iowa members with providers who are under value-based arrangements by 2018, exceeding the RFP requirements.

Aetna Medicaid has created and implemented **value-based purchasing (VBP) programs** that offer specific payment incentives for providers and systems to change their approach to care and thus reform the delivery system. Aetna Better Health will offer VBP programs to all eligible providers. The models:

- Share actionable data, combining claims and care management data and our industry leading risk stratification, predictive modeling, and population health management tools

- Assist providers with adopting expertise to move to progressive value-based payment models that start with Pay-for-Quality and can evolve to full risk
- Align resources to support local clinical collaboration and integration with our provider allies
- Focus on individualized, member-centered care management guided by Aetna Medicaid's integrated care and biopsychosocial model

To move to new payment models and gain expertise and competency with advanced population health management, providers at all capability levels must have an entry point to begin their transformation journey. From the earliest stages of their evolution, our VBP programs featured the patient-centered medical home (PCMH), ACA Section 2703 health homes, and pay-for-quality programs. These create a platform in which providers can learn and gain competencies that will enable them to move to more complex, risk-based arrangements. We believe that the entire provider continuum must have the opportunity to participate in our VBP models. In Iowa, we will involve the entire provider community.

Iowa Quality Initiatives

Our Quality Management/Quality Improvement program strategies will achieve meaningful, measurable improvements to help Iowa reach its quality goals. In this proposal, we describe:

- How we will **work with the Healthiest State Initiative** using strategies to address health risk factors, life expectancy and infant mortality, disease burden, and health infrastructure. Our tools include lifestyle change self-management resources; assessments of BMI and referral for nutritional counseling and weight management; better identification and enrollment of members in pregnancy case management; improving Care for Kids screening rates; and many others.
- How we will **work with the Mental Health and Disability Services redesign**, implementing various strategies to improve access, life in the community, person-centeredness, health and wellness, family and natural supports, and quality of life and safety. All of these are addressed directly within our ICM model, which views each person holistically and addresses their needs from a biopyschosocial perspective. Our strategies include improving behavioral and substance use disorders screening in primary care; using ICM to make care management more effective for individuals with mental health diagnoses and persons with disabilities; and supporting development of local systems of care for children with SED.
- How we will **complement Iowa's SAMHSA Substance Abuse Prevention and Treatment Block grant.** We will have initiatives to improve behavioral and substance use disorders screening. We will also use ICM and HCBS to make care management more effective for serious mental illnesses and co-occurring disorders as well as improve early identification of pregnant members with behavioral health or substance use disorders issues and enroll them into our Pregnancy Case Management program.

To incorporate the Value Index Score to drive transformation of the health care system, we will use our Value-Based Solution models that combine new payment and delivery models.

Technology

With the resources of Aetna Medicaid, Aetna Better Health will deliver a suite of technology tools—some used by members and providers and others used by health plan staff—that help directly support members and give providers and our staff the information they

Quality and Value through Simple, Relevant Solutions

need to do the right thing at the right time for the member. More importantly, these technologies provide the information at the point of decision-making, supporting our stewardship role and our value for doing the right thing for the right reason, helping to achieve the program goals of quality and affordability. Four tools that members or providers will use directly include:

- **Member website** – The member website helps members get information when and where they need it. It is compatible with Section 508 of the Americans with Disabilities Act and is also optimized for use with mobile devices. Included are features such as provider search, Member Handbook, covered services and benefits, information on how to file complaints and appeals, community resources, information on Case Management, and how to contact us.
- **Aetna Better Health App** – Every member deserves to have the right information to make good decisions. To support this right, we will offer the free Aetna Better Health app for both iOS and Android smartphones. The mobile app will have several functions to make it easier for members to find information and coordinate their health care needs.
- **Provider portal** – Providers use the portal, which includes both public and protected sections, to access the provider manual, obtain program updates, enter or check the status of prior authorization requests, check member eligibility, list their panel members, find other Aetna Better Health participating providers for referrals, and check the status of claims they have filed.
- **Utilization Management Web Interface** – An integrated, secure web-based system will let providers submit all of the necessary information for an authorization request online. This comprehensive, rules-based utilization review and authorization system simplifies and automates the review process, providing timely responses to requests.

Four technology tools that are used by health plan staff include:

- **Care Management Information System** – A fully integrated information system for physical and behavioral health care management provides a complete suite of functional, physical, and behavioral health assessments, care planning tools, and monitoring functions. With this system, an Aetna Better Health Case Manager can develop a holistic picture of the member, create a care plan that meets the member's needs, goals, and desires, and follow up to evaluate a program's effectiveness and make appropriate changes when necessary. Through remote access capability, the Case Manager can do this while face to face with the member in the field, allowing him or her to immediately answer questions, verify information, and take action.
- **Predictive Modeling** – Consolidated Outreach and Risk Evaluation (CORE) is Aetna Medicaid's proprietary, evidence-based, custom-developed tool for identifying members who will benefit most from our ICM program. CORE identifies members who are most at-risk and identifies members according to three high-risk groups: general high-risk, high-risk of an emergency department visit, and high-risk of an inpatient admission. CORE was developed specifically for use with the Medicaid population. A new capability added to CORE uses race and ethnicity factors to identify members who need outreach and management because of risk factors.
- **General Business Application System** – QNXT™ is our core operating platform. A set of 28 integrated system modules track eligibility, adjudicate claims, manage benefit packages, and support other general member and provider data management and reporting. While QNXT is in broad use across the industry, the original product was designed for the needs of Medicaid, and Aetna Medicaid configures and extends the system to support specific contract needs. EDM, the Encounter Data Management System, integrates with QNXT to manage the validation and submission of encounter data to the Agency.

- **Integrated Care Engine** – Aetna Medicaid has a dedicated data warehouse and analytics team. The warehouse—our Integrated Care Engine—aggregates data from many systems to provide reports and analytical capability to make better clinical and business decisions. It facilitates the predictive modeling capability of CORE. We designed this warehouse to meet the needs of Medicaid and can easily meet new needs as they arise; for example, integrating lab or radiology data. Using the Integrated Care Engine, our management team has the information to make effective decisions and to help DHS analyze program design changes when necessary.

Our proposal includes more information on these solutions and others; we will use them to help achieve the State's goals to improve the quality of care and health outcomes while leveraging the strength and success of current DHS initiatives.

Aetna Better Health will apply the same data warehouse and advanced expertise in analytics that Aetna Medicaid used to help Coventry Health Care and DHS to find a way to preserve the Iowa Health and Wellness Plan program.

Health Information Exchange

The Iowa Health Information Network (IHIN) will have a major role in our overall Population Health Management strategy. By combining information from Admission, Discharge, and Transfer (ADT) documents and other clinical data on the IHIN with Aetna Better Health internal data and clinical workflow, we can make a profound impact on reducing hospital readmissions and Emergency Department (ED) utilizations, thus improving the health of our members. Aetna has a long history of integration with Health Information Exchange platforms and fully understands the technology, processes, and requirements. We understand that this will be an evolutionary process. For example, we may need to begin with secure messaging, then connect directly with the five major health systems in the State for nightly ADT exchange, then add real-time ADT exchange with the IHIN.

Our Community Provider Interface, as part of our Integrated Care Technology Platform, will fully complement IHIN. While IHIN provides meaningful data to health care providers, integration of IHIN with our systems and processes transforms data into actions with measurable outcomes. We will:

- Provide resources and expertise to facilitate integration with Aetna Medicaid systems.
- Use the Community Provider Interface to help Aetna Better Health providers in the state to access select care management data in combination with data from the IHIN. This will be a significant incentive for providers to join our network.
- Demonstrate the benefits of integrated model of care management with IHIN to facilitate communication, collaboration, and information sharing among stakeholders.
- Train providers and care team members on how to use Aetna Medicaid tools and applications.

Our mission and tools combined with IHIN capabilities will help providers and members produce quality outcomes. Providers who are connected can use our infrastructure for all of our members; our approach can communicate with other electronic health record systems and is not system-specific. There will be no cost to providers for joining the program.

Why Aetna Better Health is the Right Choice for Iowa

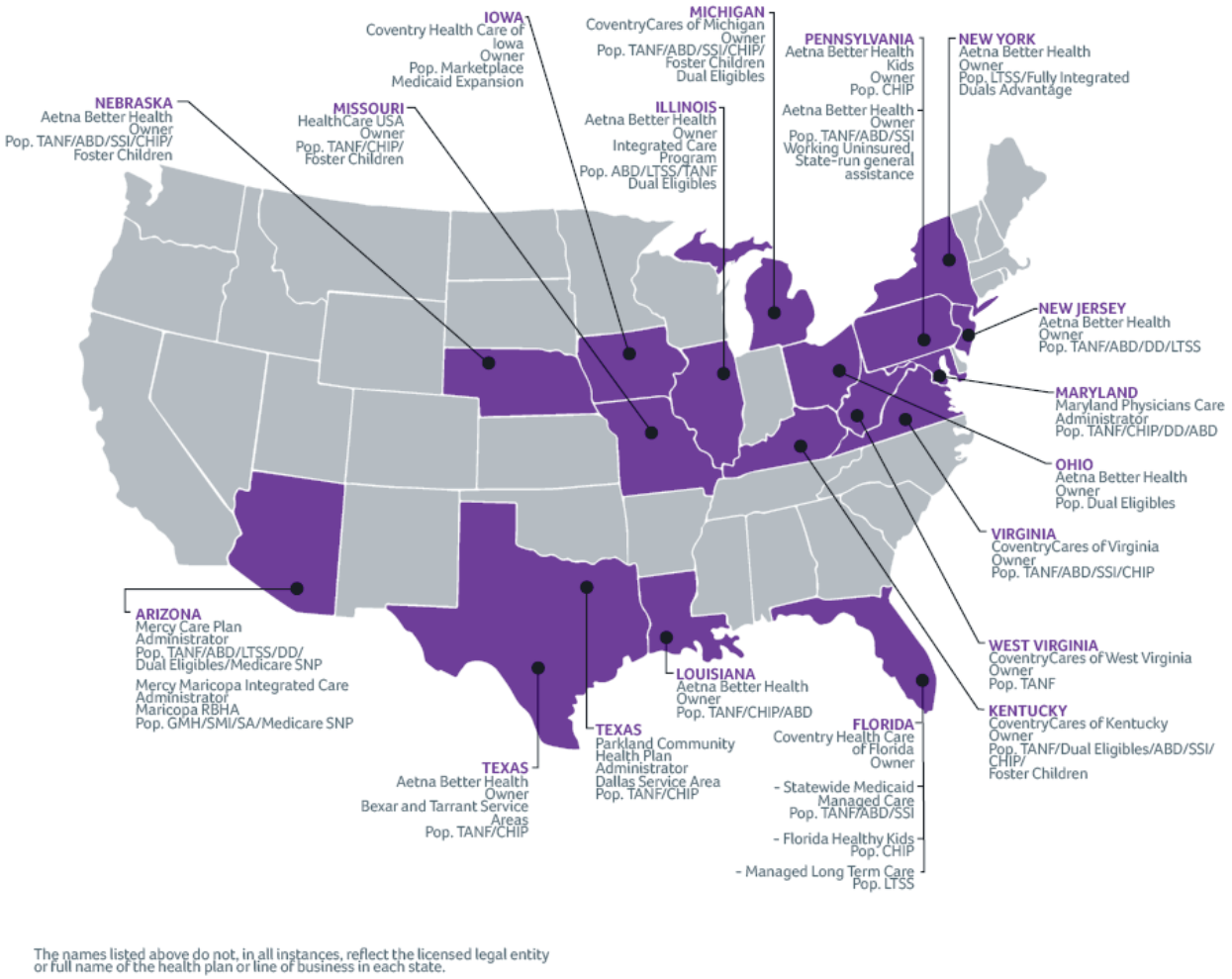
Aetna Better Health is the right choice because of our history and experience, the results we have delivered for similar programs, and our presence in and commitment to Iowa. We highlight each below.

History and Experience

Aetna Better Health and Aetna Medicaid

Aetna Better Health will leverage the experience of Aetna Medicaid, a **leader in Medicaid managed care since 1986 that currently serves nearly 3 million members in 17 states.** With nearly 4,000 employees and over 1,000 more in dedicated claims, information technology, finance, actuarial, and other roles, Aetna Medicaid has the experience, resources, and infrastructure to support Aetna Better Health in Iowa. Figure 1-1 provides a geographic overview of Aetna's Medicaid experience.

Figure 1-1: Aetna Medicaid map



In 2007, Aetna acquired Schaller Anderson, Inc., a privately-held Medicaid managed care company that was founded in 1986. Founders Don Schaller and Joe Anderson had been the director and deputy director of the Arizona Medicaid program in 1981, at the time of its creation as the first fully-capitated statewide managed care program in the nation. This success was followed by the creation of the Arizona Long-Term Care System (ALTCS) in 1989, which was the first statewide fully-capitated managed care program for individuals eligible for institutional care. Throughout that decade and those that followed, Schaller Anderson remained at the forefront of innovation in Medicaid managed care as states across the nation emulated Arizona's success. Aetna Medicaid has built upon this foundation as it has

expanded its reach across the nation. Both Aetna Better Health and Aetna Medicaid will leverage the resources and infrastructure of their 160-year-old parent company, Aetna, Inc.

Three Decades of Caring for Those Most Vulnerable

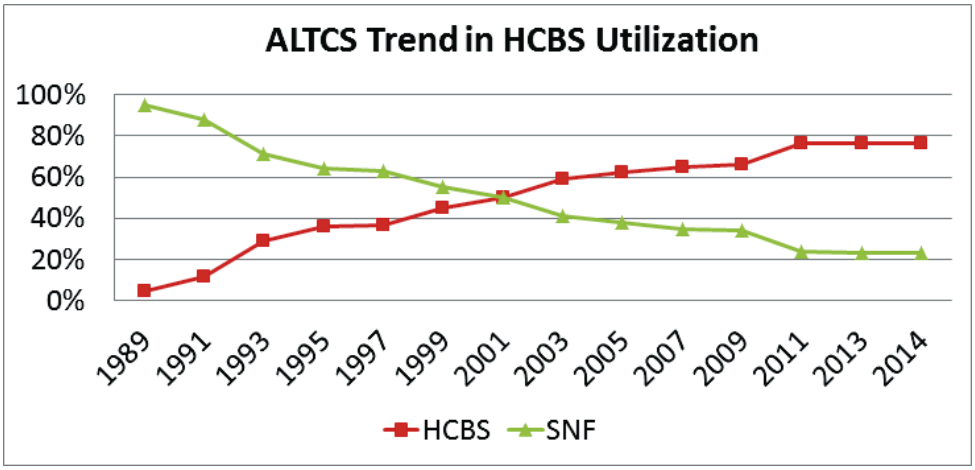
Aetna Medicaid has **30 years of experience** in managing the care of the most vulnerable, using innovative approaches to achieve successful health care results and favorable cost outcomes. Aetna Medicaid has particular expertise serving high-need Medicaid members, including over 190,000 ABD members; over 37,000 in dual eligible programs and nearly 11,000 duals where we cover only the Medicaid benefit; nearly 25,000 in specific LTSS programs; nearly 19,000 SMI members; and over 10,000 members in Intellectual / Developmental Disability or DD programs. Our experiences, and the services we offer, are consistent with the scope of services the Agency is asking us to perform.

Results for Similar Programs

Our LTSS and HCBS programs focus on helping the member live successfully in the community based on the member's choice. As Figure 1-2 shows, our results show the impact of managed care in diverting members to community-based services. Aetna Medicaid helped the state of Arizona achieve a dramatic improvement of the HCBS Ratio in the LTSS program.

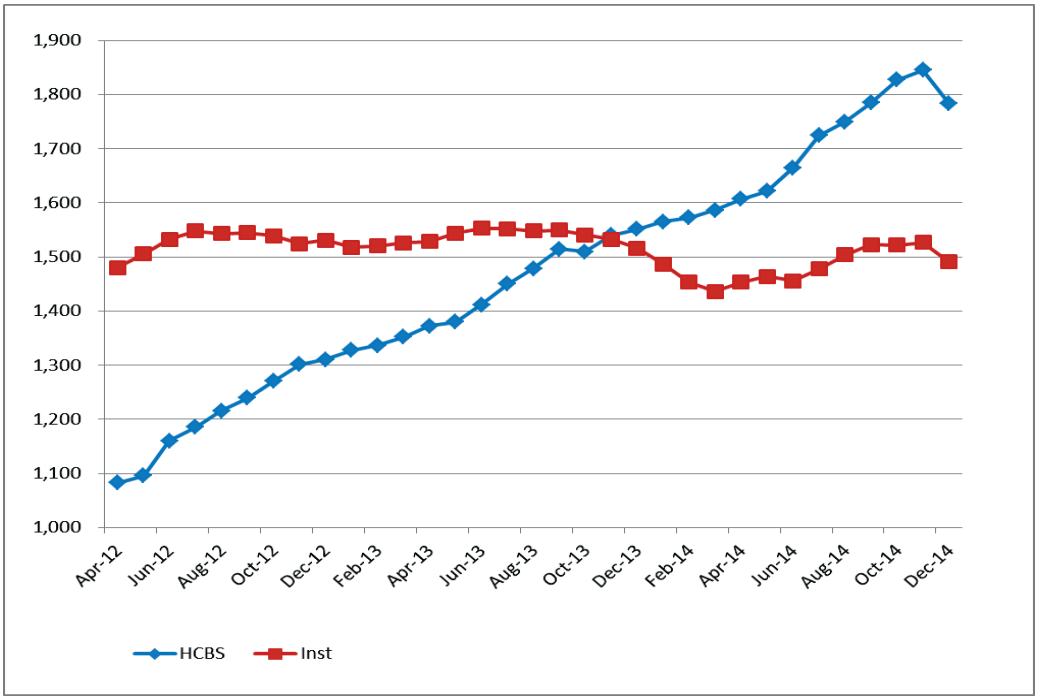
- From 1993 - 2002, the ratio improved by an average 3% per year
- From 2003 - 2008, the ratio improved by an average 2% per year
- From 2009 - 2014, the ratio improved by an average 1.2% per year

Figure 1-2: HCBS Ratio Improvement in AZ: 1993 - 2014



Our results in Delaware, shown in Figure 1-3 below, show our ability to increase use of home- and community-based services while decreasing use of institutional facilities. **The plan successfully improved the HCBS ratio by approximately 7% over two years.**

Figure 1-3: Delaware LTSS rebalancing since program start in 2012



Our Value

Independent Analysis: A 2012 analysis by Avalere showed that members in a plan managed by Aetna Medicaid in Arizona, after adjustment for risk, made higher use of preventive/ambulatory services and had lower rates of inpatient utilization, emergency department utilization, and all-cause readmissions relative to patterns of care for dual eligibles enrolled in Original Medicare (FFS). When compared to the total national FFS dual eligibles, and adjusted to match the risk of the FFS dual eligibles, the member population exhibited:

- **3% higher proportion of beneficiaries accessing preventive/ambulatory health services**
- **31% lower discharge rate (as a measure of inpatient utilization)**
- **43% lower rate of days spent in the hospital (as a measure of inpatient utilization)**
- **19% lower average length of stay (as a measure of inpatient utilization)**
- **9% lower rate of ED visits**
- **21% lower readmission rate**

Presence in and Commitment to Iowa

Stability, Competency, and Trust in the Face of Challenge

Our parent organization, Aetna Inc., has been operating in Iowa since 1985, and our commercial and Medicare plan in Iowa today serves over 178,000 members including over 10,000 members who are eligible for Medicaid. Our existing commercial and Medicare network in Iowa has 20,304 physicians (Primary Care Providers and specialists) and over 4,000 facilities (hospitals, ambulatory surgical centers, skilled nursing facilities, radiology centers, etc.). We are not new to the state; rather, we have institutional knowledge about Iowa that we will leverage as we create our provider network for the State. Because of Aetna Medicaid's decades of experience in contracting provider networks in rural areas, we understand the access challenges facing Iowa.

Explore Ideas to Make the World a Better Place

We will complement our Iowa provider network with relationships with community organizations, agencies, and faith-based services throughout the State. During our development work, we have traveled throughout Iowa to have conversations with providers and community organizations about what is most needed to serve members. A particular emphasis will be to minimize administrative burden to allow providers to focus on serving members.

Through our relationships with existing Aetna Medicaid plans in Iowa's border states of Missouri, Nebraska, and Illinois and the provider networks they have in place, we strengthen our resource base for Iowa operations. See Figure 1-4.

Figure 1-4: Plans in neighboring states will provide network relationships to serve Iowa

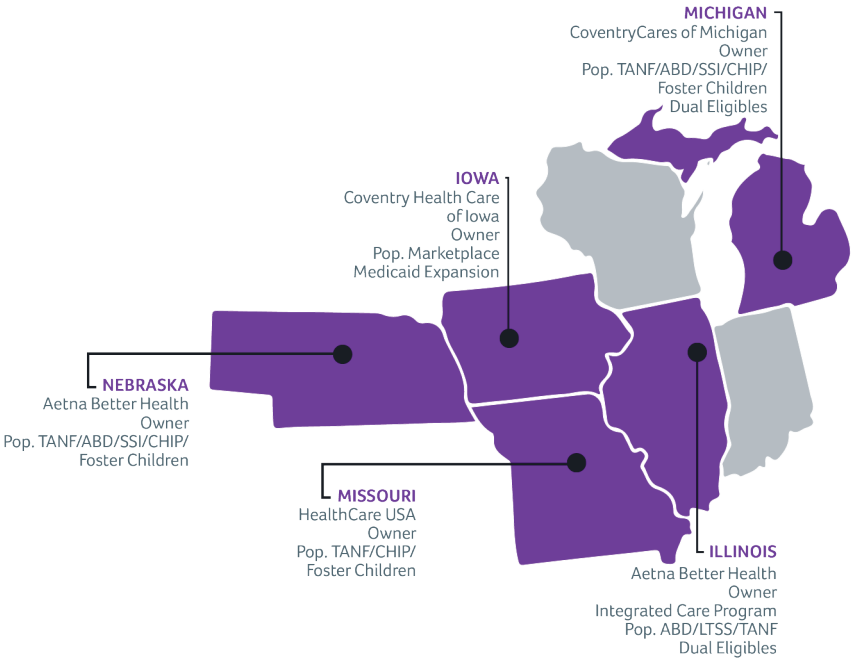


Figure 1-5 (also provided in Section 2.11, Question 1 in larger format) shows many of of the providers and organizations with whom we have had discussions; we will continue to work with these as we implement and operate the contract.

Figure 1-5: [redacted] **-CONFIDENTIAL**

[redacted]

As we crisscrossed the State, introducing ourselves, sharing our philosophy and listening to issues and concerns about managed care, we made a deliberate decision not to ask for letters of support from people we had just met. Even though these letters were often offered and, in some cases, sent to our corporate headquarters unsolicited, we chose not to include them in this proposal. Why? Because we believe that trust is something that is earned through action and over time. We are confident we will earn the trust, and support, of Iowa providers and stakeholders but also know that it takes more than asking for a signed letter to do so. The map above (Figure 1-5) tells the Aetna Medicaid story of the actual time and resources we have only just begun to commit to the State of Iowa and that will evolve throughout the lifecycle of our managed care contract.

Even more important is our commitment and persistence to making programs work effectively to serve members and doing the right thing no matter where we are. In the following sections, we talk about how we helped preserve the Iowa Health and Wellness Plan vision and how we rose to the challenge in Kentucky when another Medicaid managed care plan suddenly exited the program.

Preserving the Iowa Health and Wellness Plan Vision

BIRTH OF IOWA HEALTH AND WELLNESS PLAN

Iowa Health and Wellness Plan was Governor Branstad's signature health care program; Iowa would be one of the first states to pursue Medicaid expansion under a private option. Iowa Health and Wellness Plan was quickly approved by the legislature and Centers for Medicare and Medicaid Services (CMS), allowing the State to recruit insurers to participate in Iowa Health and Wellness Plan. The Iowa Medicaid program would subsidize those members purchasing Iowa Health and Wellness Plan coverage on the

exchange through the Marketplace Choice Plan. Larger insurers in the state chose not to participate. Coventry Health Care (CHC) chose to participate, as did Co-Opportunity Health (the Co-Op), the nonprofit cooperative funded under the Affordable Care Act.

CHALLENGES TO SUCCESS

The program began in January 2014. Despite strong enrollment and a smooth start, it quickly became apparent that premiums were not covering actual costs. The Co-Op faced the same challenges. In September 2014, the Co-Op notified the Agency that it would be exiting Iowa Health and Wellness Plan. The State moved the members to the fee-for-service Wellness Plan. Soon, the Co-Op was placed into receivership, as the unpaid claims on their books exceeded their available funds.

"I remember getting a call on December 24 of last year that the Co-op was going to be going into receivership and that we needed to help through that transition," said Pamela Sedmak, CEO. "By January 2015 we found that our own costs had continued to accelerate greater than expected and we would need greater rate increases to sustain the program. This is when the Medicaid team became intensely involved. We knew this program was very personal to the governor and his team, and knew the state could not support a large rate increase. We needed a better solution."

WORKING TOGETHER TO CREATE A SOLUTION FOR IOWA

In January 2015, Ms. Sedmak and other Aetna leaders met with the governor's office, state policy leaders, and representatives from the Agency and the Iowa Insurance Division to brainstorm how we could save the Iowa Health and Wellness Program. Ms. Sedmak proposed that they discuss a solution. "We said, 'What can we do together in the next three weeks to see if we can save this program?' And that's what happened."

The group held a working meeting to create a plan to preserve Iowa Health and Wellness Plan. Aetna Medicaid's Informatics, Actuarial, and Medical Management teams developed an analytical methodology to identify Iowa Health and Wellness Plan members who were medically frail or at high-risk. We then contacted those members and transferred them to the Medicaid fee for service program, as medically frail members were better serviced by that program. Simultaneously, Iowa officials filed a request with CMS for an emergency rate increase and permission to cap Coventry's enrollment. These actions made the program financially viable and made it possible to continue coverage for Iowa Health and Wellness Plan members through the end of 2015.

A WIN-WIN SOLUTION

Ms. Sedmak said, "It took incredible collaboration with the State and the Aetna Medicaid team, and resulted in a win-win for the state, the taxpayers, the members, and for us. We are proud to be part of the solution for this program." **The same dedicated executives that were part of the solution for Iowa Health and Wellness Plan will deliver on the promise of transformation for the Iowa High Quality Healthcare Initiative.**

Rising to the Challenge in Kentucky

We have a reputation for persisting through difficulties that have made others walk away. When a Medicaid managed care contractor terminated its contract on short notice with the Commonwealth of Kentucky effective Friday July 5, 2013 at 11:59 p.m., we rose to the challenge of bringing 68,000 of the outgoing health plan's Medicaid members on board immediately. We received the eligibility file mid-morning the next day. These members had no idea they had been transitioned to a new health plan overnight. We worked hard to make it a seamless transition for providers and new members while

continuing to provide the best service for our existing 200,000 members. Despite the challenges, we were able to meet the needs of our new membership.

The results at the end of the transition were significant. We completed 1,100 case management contacts, which allowed us to:

- Identify 83 members who were high-risk obstetrical patients
- Contact all new organ transplant members and begin full medical reviews for each member
- Manage 50 behavioral health transitions-of-care; contacted affected members to identify care needs

Our Member Services staff continued to experience an influx of calls from new members and achieved the highest service levels and the best average speed-to-answer rates, maintaining call-service levels at close to 99% with an average abandonment rate of less than 1%.

AETNA BETTER HEALTH® OF IOWA

Section 2: RFP Administrative Requirements

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SECTION 2 – GENERAL AND ADMINISTRATIVE REQUIREMENTS

The table below outlines how the Scope of Work (SOW) provided in RFP Attachment 1 relates to the responses to the questions provided in RFP Attachment 5. We provide this table to reduce redundancy of responses and information and to simplify the evaluation process.

For requirements in Attachment 1 that do not require a detailed response, the table below indicates our intent to comply with the stated requirement.

Attachment 1 requirement	Cross reference to Attachment 5	Will comply
2.1 Licensure/Accreditation	Heading	Yes
2.1.1 Licensure	Section 2.1, Questions 1 and 2	Yes
2.1.2 Accreditation	Section 2.1, Question 3	Yes
2.2 Subcontracts	Heading	Yes
2.2.1 Subcontractor Qualifications	Section 2.2, Question 2	Yes
2.2.2 Subcontractor Oversight	Section 2.2, Question 4	Yes
2.2.3 Subcontractor Financial Stability	Section 2.2, Question 2	Yes
2.2.4 Excluded Subcontractors	--	Yes
2.2.5 Integrated Subcontracting	Section 2.2, Question 6	Yes
2.3 Financial Stability	Section 2.3, Question 1	Yes
2.3.1 Solvency	--	Yes
2.3.1.1 Insolvency Protection Account	--	Yes
2.3.1.2 Surplus Fund	Section 2.3, Question 1	Yes
2.3.1.3 Working Capital	--	Yes
2.3.2 Reinsurance	Section 2.3, Question 2	Yes
2.3.3 Risk Adjustment	--	Yes
2.3.3.1 LTSS Population	--	Yes
2.3.3.2 Non-LTSS Population	--	Yes
2.3.5 Annual Independent Audit	Section 2.3, Question 2	Yes
2.3.6 Quarterly Financial Reporting	--	Yes
2.3.7 Insurance Requirements	--	Yes
2.4 Maintenance of Records	Heading	Yes
2.4.1 Financial Records	Section 2.4, Question 1	Yes
2.4.2 Medical Records	Section 2.4, Question 1	Yes
2.4.3 Response to Records Requests	--	Yes
2.5 Disclosures	Heading	Yes
2.5.1 Information on Persons Convicted of Crimes	Section 2.5, Question 1	Yes
2.5.2 Information Related to Business Transactions	Section 2.5, Question 1	Yes
2.5.3 Ownership Disclosures	Section 2.5, Question 1	Yes
2.5.4 Reporting Transactions with Parties in Interest	Section 2.5, Question 1	Yes
2.5.4.1 Definition of a Party in Interest	--	Yes
2.5.4.2 Types of Transactions Which Must Be Disclosed	--	Yes
2.5.4.3 Financial Disclosures for Pharmacy Services	--	Yes
2.5.4.4 Information to be Disclosed	--	Yes

Attachment 1 requirement	Cross reference to Attachment 5	Will comply
2.6 Debarred Individuals	Section 2.6, Question 1	Yes
2.7 Medical Loss Ratio	--	Yes
2.8 Organizational Structure	Section 2.8, Question 1	Yes
2.9 Staffing	--	Yes
2.9.1 Staffing Requirements	--	Yes
2.9.2 Staffing Plan	Section 2.9, Questions 1 and 4	Yes
2.9.3 Key Personnel	Section 2.9, Questions 1 and 3	Yes
2.9.3.1	Section 2.9, Question 1	Yes
2.9.3.2	Section 2.9, Question 1	Yes
2.9.3.3	Section 2.9, Question 1	Yes
2.9.3.4	Section 2.9, Question 1	Yes
2.9.3.5	Section 2.9, Question 1	Yes
2.9.3.6	Section 2.9, Question 1	Yes
2.9.3.7	Section 2.9, Question 1	Yes
2.9.3.8	Section 2.9, Question 1	Yes
2.9.3.9	Section 2.9, Question 1	Yes
2.9.3.10	Section 2.9, Question 1	Yes
2.9.3.11	Section 2.9, Question 1	Yes
2.9.3.12	Section 2.9, Question 1	Yes
2.9.3.13	Section 2.9, Question 1	Yes
2.9.3.14	Section 2.9, Question 1	Yes
2.9.3.15	Section 2.9, Question 1	Yes
2.9.3.16	Section 2.9, Question 1	Yes
2.9.4 Staffing Changes	Section 2.9, Question 4	Yes
2.9.5 Business Location	Section 2.9, Question 5b	Yes
2.9.6 Out of State Operations	Section 2.9, Question 5a	Yes
2.9.7 Staff Training and Qualifications	Section 2.9, Questions 4e, 6, 7, and 8	Yes
2.10 DHS Meeting Requirements	--	Yes
2.11 Coordination with Other State Agencies and Program Contractors	Section 2.11, Question 1	Yes
2.11.1 Program Contractors	Section 2.11, Question 1	Yes
2.11.2 Iowa Department of Public Health	Section 2.11, Question 1 Section 2.11, Question 2	Yes
2.11.3 Iowa Department of Education	Section 2.11, Question 1	Yes
2.11.4 DHS Division of Mental Health and Disability Services	Section 2.11, Question 1	Yes
2.11.5 DHS Division of Adult, Family and Children Services (ACFS)	Section 2.11, Question 1	Yes
2.11.6 Ombudsman's Office	Section 2.11, Question 1	Yes
2.11.7 Community-Based Agencies	Section 2.11, Question 1	Yes
2.11.8 Iowa Department of Inspections and Appeals	Section 2.11, Question 1	Yes
2.12 Media Contacts	Section 2.11, Question 1	Yes

Attachment 1 requirement	Cross reference to Attachment 5	Will comply
2.13 Written Policies and Procedures	Section 2.13, Question 1	Yes
2.14 Participation in Readiness Review	Section 2.14, Question 2	Yes
2.15 Confidentiality of Member Medical Records and Other Information	--	Yes
2.16 Material Change to Operations	--	Yes
2.17 Response to State Inquiries & Requests for Information	--	Yes
2.18 Dissemination of Information	--	Yes
2.19 DHS Ongoing Monitoring	--	Yes
2.20 Future Program Guidance	--	Yes

2.1 Licensure and accreditation

Please explain how you propose to execute Section 2 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Aetna has 30 years of relevant experience managing populations similar to those in Iowa's High Quality Healthcare Initiative

Three Decades of Caring for Those Most Vulnerable

We have relevant experience related to all general and administrative requirements in this RFP. In particular, we excel in the management of high acuity populations and the integration of physical and behavioral health care, including those individuals requiring Long Term Services and Supports (LTSS). Our goal is to upgrade current services and enhance member access to care and quality of care to create a new High Quality Healthcare (HQHC) model for Iowa.

We have more than 30 years of experience managing the care of the most medically vulnerable including preventive, acute, and chronic disease services for Medicaid members. We know the ins and outs of complex, changing regulations. Aetna Medicaid (*Aetna Medicaid is comprised of Aetna Medicaid Administrators LLC, along with its affiliates that support the organization's Medicaid operations*) has particular expertise in serving high-need Medicaid members, including those who need long-term care services and supports and those who are dually eligible for Medicaid and Medicare.

Attachment 5 – Section 2.1, Question 1 [SOW 2.1.1]

Indicate if you are currently licensed as an HMO in the State of Iowa. If you are not currently licensed, describe your plan to achieve licensure.

Licensure as an HMO in Iowa

Aetna Better Health of Iowa Inc. (Aetna Better Health) has submitted our application for licensure as an HMO in the state of Iowa. We are confident we will be licensed before the anticipated start date for the provision of services for this contract.

Attachment 5 – Section 2.1, Question 2 [SOW 2.1.1]

Indicate whether you are currently a qualified health plan (QHP) issuer certified by the Iowa Healthcare Exchange.

A Qualified Health Plan issuer certified by Iowa Healthcare Exchange

Stability, Competency, and Trust in the Face of Challenge

Coventry Health Care of Iowa Inc. is a Qualified Health Plan issuer certified by the Iowa Healthcare Exchange. Coventry Health Care of Iowa Inc. and Aetna Better Health are affiliates with the same ultimate parent company.

Attachment 5 – Section 2.1, Question 3 [SOW 2.1.2]

Indicate whether you are currently accredited by the NCQA. If you are not currently accredited, describe your plan to achieve accreditation.

Aetna Better Health will obtain NCQA accreditation

As indicated by the NCQA, a new health plan must be operational for six months before applying for NCQA accreditation. Because Aetna Better Health is a new entity, we are not currently accredited by NCQA. Upon contract award and after being operational for six months, Aetna Better Health will file for Interim Health Plan NCQA accreditation in Iowa for Medicaid on the earliest date allowed by NCQA. We will begin this process on or before the contract effective date [SOW 2.1.2] and pursue full health plan accreditation at the earliest opportunity allowed by NCQA.

Currently, Aetna has 186 health plans accredited by NCQA. Approximately 50% of all Aetna Health Plans are accredited at the commendable or excellent levels.

To prepare for NCQA accreditation, we will use external reviewers to conduct mock audits to assess our policies, processes, and procedures against NCQA standards. Seeking and achieving accreditation is directly related to our core value of excellence. Aetna has current Health Plan accreditation in Iowa for our Commercial, Medicare, and Marketplace (Exchange) lines of business. All Aetna Health Plan policies, procedures, operations, and programs are established to meet NCQA standards.

Current NCQA accreditations in Iowa

Current NCQA accreditations held in the State of Iowa are presented in Table 2-1.

Table 2-1: Aetna's Current Iowa Business NCQA Accreditation

Health Plan	Aetna Owned/ Administered	Product	Accrediting Entity	Accreditation Type	Current Accreditation Status	Expires
Aetna Life Insurance Company (Iowa) Aetna Open Choice	Owned	Commercial PPO	NCQA	Health Plan	Accredited	1/24/2017
Coventry Health Care of Iowa, Inc.	Owned	Commercial HMO/ POS	NCQA	Health Plan	Accredited	12/26/2016
Coventry Health & Life Insurance Company, Inc.	Owned	Commercial PPO	NCQA	Health Plan	Accredited	12/26/2016
Coventry Health Care of Iowa, Inc.	Owned	Marketplace Exchange HMO/ POS	NCQA	Health Plan	Accredited	12/26/2016

We confirm that NCQA accreditation will be maintained throughout the life of the Contract at no additional cost to the Iowa Department of Human Services (the Agency). We understand and agree that

when accreditation standards conflict with the standards set forth in the Contract, the Contract prevails unless the accreditation standard is more stringent.

2.2 Subcontracts

Attachment 5 – Section 2.2, Question 1

Summarize your proposed subcontracts, including any with parent companies, and key work to be delegated under the subcontracted relationship.

Proposed subcontracts and key work

Aetna Better Health will use subcontractors as defined in the RFP. We contract with both Aetna-affiliated and non-affiliated subcontractors. It is our policy to contract with Aetna affiliates for services in support of the Contract to the fullest extent possible because it allows us to more closely monitor and promote quality and compliance.

Our primary considerations as we select non-affiliated subcontractors are service, cost, and compliance. We select and use non-affiliated subcontractors only when we are certain the subcontractor will perform the services as well as—or better than—we would be able to, due to:

- Established service relationships with our members and providers
- Specific experience or expertise
- Greater capacity

Table 2-2 lists our proposed subcontractors and parent companies and the services of each.

Table 2-2: [redacted] **– CONFIDENTIAL**

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Organizational chart showing subcontractor relationships

Please see our response to Tab 4, RFP Section 3.2.5.1.5 Experience Managing Subcontractors for a summary of our experience working with subcontractors and Figure T4-2 in Section 3.2.5.1.5 for an organizational chart of Aetna Better Health of Iowa's parent and subcontracted affiliates.

Please see Figure 2-1-Organizational Chart of Proposed Subcontractors below for the contractual relationship of Aetna Better Health and our proposed subcontractors for the Iowa High Quality Healthcare Initiative (the Initiatives).

Figure 2-1: [redacted] **– CONFIDENTIAL**

[redacted]

Attachment 5 – Section 2.2, Question 2 [SOW 2.2.1, 2.2.3]

Indicate if any of the subcontracts are expected to be worth at least five percent (5%) of capitation payments under this contract.

The subcontracts expected to be worth at least 5% of capitation payments under this contract include:

- **Aetna Medicaid**, our affiliate. Aetna Better Health will contract with Aetna Medicaid for the provision of medical and other services under the Contract, enabling Aetna Better Health to benefit from our own local experience in Iowa while continuing to receive support from our affiliate as needed.
- **CVS Health** is subcontracted with for pharmacy benefits management, pharmacy network, and mail-order pharmacy.

Attachment 5 – Section 2.2, Question 3 [SOW 2.2.1]

Describe the metrics used to evaluate prospective subcontractors' abilities to perform delegated activities prior to delegation.

We hold ourselves accountable for our subcontractors

Aetna Better Health will be accountable for any functions and responsibilities delegated to a subcontractor and will certify and warrant all subcontractor work. Before delegation, we will evaluate the prospective subcontractor's ability to perform the activities to be delegated, including firm and staff qualifications.

Subcontracts will be supported by a written agreement that specifies the activities and reporting responsibilities of the subcontractor and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. We will confirm all written subcontracts meet the requirements of 42 CFR 434.6 and will incorporate by reference the applicable terms and conditions of the Contract.

Metrics to evaluate prospective subcontractor abilities

We evaluate and choose subcontractors with which Aetna Medicaid has established successful relationships in other Medicaid managed care markets or that adhere to Aetna health plan standards and NCQA standards, as appropriate, and comply with all applicable federal and State laws and regulations. Before making a decision to subcontract, we assess the:

- Business need for subcontracting
- Cost, benefit, and the subcontractor's readiness to assume the obligations under a subcontract, including the financial integrity, management expertise, and information technology capabilities of the subcontractor
- Potential impact on clinical care and service to members

Subcontractor pre-assessment questionnaire

We use a subcontractor pre-assessment questionnaire in the decision-making process. When the subcontractor is providing administrative services, our subcontracting process includes a review of the prospective subcontractor's program for adherence to standards of the health plan, NCQA, and compliance with applicable federal and State laws and regulations. Appropriate staff reviews relevant documentation before conducting an onsite assessment.

As requested in RFP Exhibit D: Additional Certifications, if a subcontractor is involved in the development or operation of an application or web-based system that will involve the Agency's data, the subcontractor will certify that its security policies meet or exceed minimum security and privacy requirements as outlined in this Exhibit.

Use of standardized audit tools for evaluation

We use standardized audit tools for evaluation and documentation during the assessment of the prospective subcontractor's program. The completed assessment report documents the prospective subcontractor's program strengths and opportunities for improvement and is used by the Quality Management Operational Committee (QMOC) in review and approval of subcontracted relationships. At minimum, we perform an assessment of each subcontracted provider entity annually and report the results to the QMOC.

Attachment 5 – Section 2.2, Question 4 [SOW 2.2.2]

Describe the policies and procedures used for auditing and monitoring subcontractors' performance.

Ongoing evaluation of subcontractors begins before program implementation

We have developed and will implement and maintain comprehensive policies and procedures to evaluate subcontractor performance so that the needs and expectations of the state of Iowa and its citizens are met, or exceeded. Aetna Better Health, with Aetna Medicaid's support, will regularly review subcontractor performance, measure subcontractor outcomes, and evaluate subcontractor reports. Our subcontractor evaluation process will begin before program implementation and will continue throughout the term of the subcontract agreements.

Through the life of the contract, our locally based, cross-departmental team will use the reports gathered during the monitoring process to evaluate subcontractor performance and make recommendations for improving quality of care for our members and providing a high level of support to our subcontractors**.** If we identify areas for improvement, we will implement practical solutions and timely actions to result in more consistent, effective, and accessible care for our members while also providing better guidance regarding our expectations to our subcontractors.

Monitoring subcontractor performance

As part of our Quality Management (QM) program, we use a comprehensive set of policies and procedures to audit, monitor, evaluate, and manage the subcontracting of responsibility for subcontracted program functions. We routinely monitor the quality of care and services as well as the quality of reporting data subcontractors provide under any subcontract.

The written subcontract defines our ongoing monitoring of subcontractor performance and activities, including the requirement that subcontractors provide reports twice a year that include information appropriate to the scope of their functions. **For our contract with the Agency, we will conduct formal reviews at least quarterly**.

We will develop, implement, and maintain comprehensive policies and procedures regarding subcontractor performance to meet the needs and expectations of stakeholders.

We currently have quality management policies in place for delegation oversight responsibilities. Our policies require Aetna Better Health to evaluate the ability of potential delegates (including subcontractors or vendors) to perform the activities proposed for delegation. We require delegated entities to confirm the care or service the delegate provides on behalf of the health plan conforms to standards and requirements stated in the delegation agreement, meet accreditation and regulatory standards, and that activities performed on the plan's behalf are consistent throughout the network. Our policies also acknowledge that Aetna Better Health is ultimately accountable for the functions performed by our delegates.

Although we designated Aetna Better Health's Chief Executive Officer (CEO) as the senior executive responsible for overseeing the performance of subcontractors, oversight is everyone's responsibility. We regularly monitor and review performance, measure outcomes, and evaluate subcontractor reports. If we identify areas for improvement, we use this information to recommend cross-departmental strategies to improve quality of care or to determine any need for additional quality indicators to measure program performance.

OUR APPROACH TO MONITORING SUBCONTRACTOR PERFORMANCE HOLDS US ALL ACCOUNTABLE

Our Operations Department, who acts as the subcontractor's liaison, will conduct day-to-day, hands-on subcontractor monitoring. Although Operations is responsible for the daily monitoring of subcontractors, oversight is conducted by an internal and locally-based team from our Compliance, Medical Management, Quality, Health Services, and Provider Services Departments. Specifically, these departments work together to:

- Conduct readiness reviews
- Monitor adherence to performance standards through recurring administrative reports
- Review and audit subcontractor reports for compliance with contractual requirements
- Review member and provider feedback on subcontractor performance
- Recommend remedial actions, such as training or more frequent monitoring, to address subcontractor performance issues
- Notify the Agency of any subcontractor placed on a corrective action plan and track corrective action plans to satisfactory completion

Our Compliance Department interacts with Operations to discuss concerns, issues, and needs regarding subcontractors. Operations, together with our Compliance, Health Services, Medical Management, and Quality Departments, will participate regular meetings with subcontractors to educate them about topics or emphasize issues, including:

- Relevant State and federal legislation and regulations
- Contractual obligations to Iowa
- Performance expectations or concerns
- Reporting requirements

We increase the frequency of these meetings to twice a week or monthly as needed to address pressing issues, new legislation, or regulatory changes.

TAILORING OUR MONITORING METHODS FOR EACH SUBCONTRACTOR

We will determine the type and level of monitoring on a case-by-case basis depending on the subcontractor, the services being provided under a subcontract, and the subcontractor's performance history with Aetna Better Health. As part of our monitoring process, we will require the subcontractor to submit reports in a manner and frequency that meets our contractual obligations with Iowa. These reports include information about performance against the metrics, standards, and service-level agreements defined in the subcontract. This information is cross-referenced with member feedback and peer-to-peer reviews to establish accuracy in reporting.

Aetna works with subcontractors to improve performance

We confirm that the Agency reserves the right to audit subcontractor data. Whenever deficiencies or areas of improvement are identified, Aetna Better Health and the identified subcontractor will take

corrective action. We will provide to the Agency the findings of all subcontractor performance monitoring and reviews upon request and will notify the Agency any time a subcontractor is placed on corrective action.

Reporting subcontractor performance

Additionally, we confirm that the Agency will provide to Aetna Better Health, through the Reporting Manual, any reporting requirements for incorporating subcontractor performance into the reports to be submitted to the State.

Attachment 5 – Section 2.2, Question 5

Describe the enforcement policies used for non-performance, including examples.

We proactively address a subcontractor's failure to meet standards

Aetna Better Health will contractually require our subcontractors to follow all pertinent federal and Iowa laws and regulations. If a subcontractor fails to meet any applicable standard, we may pursue various sanctions, remedial actions, or other remedies as a result of such failure, per the terms of the applicable subcontract. Our remedies will include:

- Requiring the subcontractor to cure any breach and provide a corrective action plan, evidencing appropriate controls are in place to prevent future breaches
- Pursuing indemnification from any subcontractor for any financial penalty, fine, or interest assessed against us as a result of the subcontractor's failure to meet required standards, or offsetting the amount of any such penalty, fine, or interest against payments we owe to the subcontractor
- Assessing performance credits against subcontractors if they fail to meet designated standards for claims processing and encounters

We will use any, or all, of these remedies to address a subcontractor's non-compliance. If not resolved, or if the subcontractor repeatedly fails to meet service levels or bring performance into alignment with applicable standards, we may terminate the subcontract for material breach of contract.

Attachment 5 – Section 2.2, Question 6 [SOW 2.2.5]

Describe how subcontracting relationships will provide a seamless experience for members and providers.

Integrated subcontracting – a seamless experience for members

Our subcontracting relationships will provide a seamless experience for members and providers.

STRONG CORPORATE STRUCTURE TO SUPPORT IOWA HIGH QUALITY HEALTHCARE

Aetna Inc. is Aetna Better Health's ultimate parent. Aetna Better Health is wholly owned by Aetna Health Holdings, LLC (Aetna Health Holdings). Aetna Health Holdings is wholly owned by Aetna Inc.

Aetna's established arrangements for integrated subcontracting provide seamless support to meet the needs of providers and nearly 3 million people in 17 states.

Aetna Inc. was established in 1853 and is one of the nation's leading diversified health care benefits companies. To support the Iowa High Quality Healthcare Initiative, we will contract with an affiliate, Aetna Medicaid Administrators LLC (Aetna Medicaid Administrators), for management and operations services provided under an administrative services agreement. We will also receive certain limited administrative services from our affiliate Aetna

Health Management, LLC (AHM), through a subcontract between AHM and Aetna Medicaid, as well as certain limited services from our affiliate Aetna Life Insurance Company, a subcontractor of AHM.

LOCAL IOWA PRESENCE AND NATIONAL RESOURCES

Local Based Plan Aetna Medicaid will provide a broad array of management and operations services under an administrative services agreement. Aetna Better Health affiliates and subcontractors who are not affiliates will furnish additional services.

Aetna Better Health will use subcontractors that are affiliates, have established a positive presence in Iowa, or with which Aetna Medicaid has developed a successful relationship in our other Medicaid managed care markets. Local, Iowa-based staff will run our Iowa-based operations. This approach will facilitate success during implementation and ease transition to steady-state operations.

Aetna Better Health's preference is to contract with our affiliates. Aetna Medicaid will be our primary subcontractor for the Iowa High Quality Healthcare Initiative. Aetna Life Insurance Company will provide procurement management, and Aetna Health Management, LLC will support provider credentialing.

This model of a local, community-based health plan run by Iowa-based staff and supported by Aetna Medicaid, will benefit our Iowa members threefold, by providing our local focus, broad Medicaid and health plan knowledge and experience, and national resources.

We will require our subcontractors to demonstrate adherence to our health plan standards, NCQA standards, and compliance with all applicable State and federal laws and regulations.

Quality and Value through Simple, Relevant Solutions

Any subcontractors used to provide direct services to members, such as behavioral health services, will meet the same requirements as Aetna Better Health. We provide a description of our policies and procedures used for oversight and monitoring of the subcontractors in response to Section 2.2, Question 4.

SUBCONTRACTORS PROVIDING DIRECT SERVICES – QUALITY IMPROVEMENT GOALS

We require subcontractors providing direct services to have quality improvement goals and performance improvement activities specific to the types of services provided by the subcontractors. We monitor subcontractors quarterly and review copies of audits and oversight measures at department Quality Management meetings. We work with subcontractors to improve their performance and meet improvement goals. Our experience and methods of managing subcontractors will provide a reduction in administrative burden and make things easier for the Agency, members, and providers.

2.3 Financial stability

Attachment 5 – Section 2.3, Question 1 [SOW 2.3]

Provide verification of the financial requirements described in the subsections of Section 2.3.

Meeting, or exceeding, financial requirements

Aetna Better Health is a subsidiary of Aetna Inc., a Fortune 100 company with current favorable ratings from Standard & Poor's, Moody's, and A.M. Best. Aetna Inc. has a 156-year history of financial stability, and our financial resources far exceed this RFP's fiscal soundness requirements.

Aetna Inc., as the ultimate parent of Aetna Better Health, will direct that Aetna Better Health be capitalized to meet all state requirements and necessary startup costs.

We will be capitalized through direct contributions from Aetna Health Holdings, LLC, our parent company. We will maintain minimum capital and surplus through income from operations following the initial capitalization, and will comply with all State and federal financial requirements.

Aetna routinely assesses the financial position of each subsidiary. An estimated net worth calculation is completed one month before the close of quarterly financials. Any capital contributions needed are submitted to Aetna's capital planning for transfer of funds to the subsidiary before the close of each quarter. If the net worth of the subsidiary is deficient after the quarterly closing, the deficiency is noted on the notes to the Financial Statements and a capital contribution is requested from capital planning for immediate transfer of funds prior to the release of the financial statement. In instances where a subsidiary has needed capital, the subsidiary's parent has made and will continue to make capital contributions (without restriction) to the subsidiary.

Attachment 5 – Section 2.3, Question 2 [SOW 2.3.2, 2.3.5]

Describe how you will comply with the requirements for reinsurance. Will you obtain reinsurance contracts or submit a plan of self-insurance?

Aetna's compliance with reinsurance process

We will comply with the Agency's and Iowa Administrative Code requirements regarding reinsurance contracts. Aetna currently has several reinsurance agreements with nonaffiliated insurers that relate to health care insurance policies. We enter into these contracts to reduce the risk of catastrophic losses, which in turn reduces our capital and surplus requirements. Upon contract award, Aetna will use a third-party vendor to assist in the procurement process for obtaining reinsurance coverage, taking into account cost, covered benefits, and the risk profile of the member population. We frequently evaluate reinsurance opportunities and refine our reinsurance and risk management strategies on a regular basis.

ANNUAL INDEPENDENT AUDIT [SOW 2.3.5]

We will submit an annual audited financial report that specifies our financial activities under the Contract within six months following the end of each calendar year. The report, prepared using Statutory Accounting Principles as designated by the NAIC, will be prepared by an independent certified public accountant on a calendar year basis, at our expense.

CERTIFIED PUBLIC ACCOUNTING FIRMS FOR THE AGENCY TO SELECT

We propose one of the following three certified public accounting (CPA) firms for the Agency to use to complete an independent audit: KPMG LLP, McGladrey LLP, or Ernst & Young LLP.

2.4 Maintenance of records

Attachment 5 – Section 2.4, Question 1 [SOW 2.4.1, 2.4.2]

Describe your system for maintaining financial and medical records that fully disclose the extent of services provided to members.

Systems that maintain financial and medical records

We have Health Insurance Portability and Accountability Act (HIPAA)-compliant systems in place for maintaining financial and medical records. Our Code of Conduct requires employees to adhere to procedures governing retention of records consistent with applicable laws, regulations, company policies, and business needs. To help employees meet this requirement, our Records Retention Schedule establishes how long employees must keep each type of business record.

RECORDS RETENTION SCHEDULE

The Records Retention Schedule outlines how long employees should keep each type of business record. We apply retention schedules consistently to all business records, and in compliance with RFP Section 2.4.2. Archiving system data is based on the timeframes established for a specific record type as stated in the Records Retention Schedule.

EMPLOYEE RECORDS RETENTION TRAINING

Employees play an important role in records maintenance. Annually, employees and the employees of appropriate health care subcontractors complete records retention certification. We train employees to retain records per the Records Retention Schedule and dispose of business records once the retention period has been satisfied. Department managers oversee the creation of department–specific procedures to implement record retention requirements and coordinate the annual review of the Records Retention Schedule.

STORAGE OF RECORDS

Employees must confirm only items meeting the definition of inactive records move to offsite storage.

- **Paper Storage** – We use Iron Mountain for our offsite document storage. Iron Mountain maintains documents per the Records Retention Schedule. Records moving to offsite storage are properly labeled and contain the department cost center, record code, a description of box contents, and a date range of box contents.
- **Electronic Storage** – We have rigorous parameters around the amount of storage that each employee can retain. Electronic business records, including e-mail messages with attachments comprising records that are received, created, transmitted, or maintained using our computer systems, are preserved consistent with the Records Retention Schedule.

DISPOSAL OF RECORDS

We have secure document recycling for both paper and electronic records. For paper records, those onsite in workstations, file cabinets, and in file rooms and on shelves or media such as CDs, DVDs, USBs, and Zip drives that are onsite, employees use secure shredding material bins. Those employees who telecommute must use an Aetna-approved shredder in their home or bring the materials into the closest Aetna office to be placed into a secure shredding material bin.

2.5 Disclosures

Attachment 5 – Section 2.5, Question 1 [SOW 2.5.1, 2.5.2, 2.5.3, 2.5.4]

Provide disclosures as described in the subsections of Section 2.5.

We provide the following disclosures as described in the subsections of Section 2.5.

Information on persons convicted of crimes [SOW 2.5.1]

Neither the direct owner, indirect owner, nor any managing staff has a criminal conviction related to that person's involvement in any program under Medicare, Medicaid, or the Federal Title services program since the inception of those programs.

Information related to business transaction [SOW 2.5.2]

Aetna Better Health is not yet operational, but will not hold any ownership interest in any provider or 12-month period ending on the date of the submission of this proposal. Aetna Better Health does not

have any business transitions totaling more than $25,000.00 during the twelve month period ending on the date of the submission of this proposal with affiliated companies, however, in anticipation of becoming operational, we have described potential arrangements with affiliated companies under §2.5.4 Parties in Interest.

Ownership disclosures [SOW 2.5.3]

We will make full disclosure of ownership, management and control information for Aetna Better Health and any subcontracting entities or providers, as required by 42 CFR 455.100 through 455.106. As required by the RFP, this information is provided to the Agency with the proposal as Appendix B, and will be delivered upon Contract execution and within 35 days after any change in ownership. We agree to submit financial statements for any individuals or corporations with 5% or more of ownership or controlling interest.

Reporting transactions with parties in interest [2.5.4]

Aetna Better Health is a wholly owned subsidiary of Aetna Health Holdings, LLC, which in turn is a wholly owned subsidiary of Aetna Inc. The Health Plan anticipates that it will execute an Administrative Services Agreement with Aetna Medicaid Administrators LLC ("AMA"), which is also a wholly owned subsidiary of Aetna Health Holdings, LLC, pursuant to which AMA will provide plan management services in support of the health plan. In addition, Health Plan anticipates that it will be party to a Joinder Agreement with AMA and Aetna Health Management, LLC ("AHM"), which is also a wholly owned subsidiary of Aetna Health Holdings, LLC, pursuant to which AHM provides pharmacy benefit management services in support of the health plan. The Health Plan's affiliated subcontractor AMA anticipates that it will also be party to an intercompany Program Agreement and Amended and Restated Intercompany Master Agreement with AHM, whereby AHM provides a subset of administrative services in support of the health plan. In addition, the Health Plan will be party to the tax-sharing agreement described below.

Aetna Inc., the ultimate parent of the Health Plan, maintains a written tax-sharing agreement with its subsidiaries ("TSA"). Under the TSA, the Health Plan's current federal income tax provisions would be generally computed as if the Health Plan were filing a separate federal income tax return; current income tax benefits, including any that result from net operating losses, would be recognized to the extent realized in the consolidated return. The Health Plan is a signatory to this TSA. The Health Plan has the enforceable right to recoup federal income taxes paid in prior years, if any, in the event of future net losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes.

2.6 Debarred Individuals

Attachment 5 – Section 2.6, Question 1 [SOW 2.6]

Describe mechanisms to ensure compliance with requirements surrounding debarred individuals.

Compliance with requirements surrounding debarred individuals

The mechanisms to confirm compliance with requirements surrounding debarred individuals include:

- Aetna Better Health will conduct a monthly review of prospective and active personnel, providers, and contractors to determine they have not been sanctioned by the Office of Inspector General (OIG), the System for Award Management (SAM) database, or the Iowa state exclusion list. Should Aetna Better Health determine and verify a candidate, provider, or contractor is listed on the OIG, SAM, or state exclusion databases, we will cease employment and contracting activities. It is our

policy not to employ or contract with any individual that has been excluded from participation in state or federally funded health care programs. There is no exception to this policy.

- Should Aetna Better Health determine and verify that an Aetna Better Health personnel, provider or contractor has been added to the OIG, SAM, state exclusion or other related exclusion database, Aetna Better Health will terminate either employment or the contract. Employment termination will be consistent with the Aetna Human Resources department rules and requirements. Contract termination will be consistent with applicable contract clauses regarding terminations.
- We notify members who have relationships with terminated providers via letter.

2.8 Organizational Structure

Attachment 5 – Section 2.8, Question 1 [SOW 2.8]

Describe your proposed organizational structure and indicate which operational functions will be conducted in Iowa and which functions will be conducted out-of-state.

Proposed organizational structure

We describe our organizational structure and provide organizational charts in Tab 4, Requirement 3.2.5.2.1: Tables of Organization.

OPERATIONAL FUNCTIONS CONDUCTED IN IOWA AND OUT OF STATE

Table 2-3 indicates which operational functions will be conducted in Iowa.

Table 2-3: Operational functions conducted in Iowa and out of state

Operational Function	Conducted In Iowa
Administrative and Fiscal Management	Yes
Compliance/Program Integrity	Yes
Member Services	Yes
Provider Services	Yes
Medical Management/Care Coordination	Yes
Marketing	Yes
Provider Enrollment	Yes
Network Development and Management	Yes
Quality Management and Improvement	Yes
Utilization and Care Management	Yes
Behavioral Health and Physical Health	Yes
Information Systems	Yes and conducted in Phoenix as well
Performance Data Reporting and Encounter Claims Submission	Conducted in Phoenix
Claims Payments	Conducted in Phoenix
Grievance and Appeals	Yes

An organizational and operational structure to fulfill all contract requirements

Our organizational and operational structure is capable of fulfilling all Contract requirements; we will manage the functional linkage of all major operational areas:

- Our organizational and operational structure will support collection and integration of data across Aetna Better Health's delivery system and internal functional units to accurately report our performance.
- We will have in place sufficient administrative and clinical staff and organizational components to achieve compliance with all Contract requirements and performance standards.

Attachment 5 – Section 2.8, Question 2

Describe how your administrative structure and practices will support the integration of the delivery of physical health, behavioral health and LTSS.

Our administrative structure supports integration of services

Pioneer in Fully Integrated Care

Our strong administrative structure and practices have supported the integration of the delivery of physical health, behavioral health, and LTSS in 17 states. Our integrated care management (ICM) model is the core of everything we do. We will use the same successful structure to provide fully integrated care in Iowa.

PHYSICAL HEALTH

Our Medical Director will oversee Utilization Management (UM), Integrated Care Management, and LTSS. Each of these three departments has a manager who will oversee their programs to confirm that physical, behavioral, psychosocial, and LTSS services are coordinated and integrated. Our Director of Medical Management oversees these three managers.

BEHAVIORAL HEALTH

A Behavioral Health Manager with significant behavioral health expertise reports to the CMO and helps drive and support the integration of clinical programs at the health plan and member levels including:

- Collaborating with State allies, health and service providers in the network, and the community
- Educating clinical staff about biopsychosocial care and service coordination and planning
- Developing programs to support the needs of members with special health care needs

LTSS

Integrated Case Managers will facilitate a coordinated approach with all care team participants providing health care and services to members with physical health, behavioral health, and LTSS and social needs. Some of the most important duties that the Integrated Case Managers perform include:

- Keeping the care team—including medical, home health, behavioral, LTSS and health home providers—informed of progress and concerns
- Sharing member care plans
- Holding Integrated Care Team meetings to discuss member issues and collaborate to provide member-centered care plans
- Monitoring for gaps and duplication in services

We train our staff on network and community resources, HCBS, and specialized behavioral health services including peer support, treatment programs, crisis services, intensive outpatient programs, Partial Hospitalization Programs, residential, and day treatment programs. They are also trained in motivational interviewing, managing crises, and mental health first aid.

PIONEER IN FULLY INTEGRATED CARE

Pioneer in Fully Integrated Care

We believe in providing truly integrated care management for Iowans who are eligible for Medicaid. As a result, our local, community-based operating model includes Aetna Medicaid physical and behavioral health staff working together to assess and care for each member's care management needs. Through this integration, we prevent issues that arise from separate reporting relationships, including different motivations, standards, processes, and objectives. Instead, our behavioral health care management model *is* fully integrated into our physical health care management model, or the LTSS care management model we will employ for Iowa's forthcoming LTSS program.

2.9 Staffing

Attachment 5 – Section 2.9, Question 1 [SOW 2.9.2, 2.9.3]

Describe in detail your staffing plan and expected staffing levels.

Staffing plan and expected staffing levels

Please see Table 2-4 for list of proposed interim staffing for key personnel and Table 2-5 for additional suggested staffing. Additional detail with respect to our staffing plan and staffing levels can be found in our response to Tab 4, Section 3.2.5.2.1 in Table T4-4.

LOCAL COMMUNITY-BASED PLAN – IOWANS SERVING IOWANS

Local Community-Based Plan - Iowans serving Iowans

An important distinction between Aetna Better Health and others: while the telephone and the Internet are useful tools, **there is no substitute for being there – in Iowa** – helping solve problems with the member, with the provider, and with the community. All of our member- and provider-facing staff will be in the local community. For this contract, based on our current enrollment projections, we will have more than 400 people in Iowa. **We will be hiring Iowans for these jobs.** Our Case Managers will be in the community, not in a call center. They go where they are needed, to see, connect, and gain the trust of our members. Provider Services Representatives will make direct office visits in Iowa to educate, answer questions, and solve problems. Community Development Coordinators will create, coordinate, and produce educational appearances at local events, providing important health information for all Iowans who attend, not just Aetna Better Health members. Even Member Services Representatives who answer phones will be in Iowa offices – so they will speak from experience as they help beneficiaries address questions and access care. **We are not guessing what Iowa might be like; we know.**

Pioneer in Fully Integrated Care

To deliver individually tailored service coordination and exceptional customer service to members, caregivers, and providers in our Iowa LTSS population, we will use the experience gained by Aetna Medicaid in more than 25 years of experience serving LTSS members in Arizona, Delaware, Florida, Illinois, Michigan, New Jersey, New York, and Ohio. In these, we have honed our approach to serving highly complex and frail populations with diverse benefits. We are equipped to successfully manage the varying benefits, cost shares, and eligibility requirements of the Iowa LTSS and Home and Community-Based Services (HCBS) waiver populations.

Our Integrated Care Management (ICM) program recognizes that every person is best cared for in a holistic manner. ICM integrates every aspect of care – physical, behavioral, and functional – in a unified team and set of processes. It does so under one roof; Aetna Better Health **does not outsource program components.** Physical and behavioral health clinicians, including physicians, registered nurses and

advanced practice nurses, and licensed behavioral health specialists work face-to-face and side-by-side daily to identify members who have complex needs; assess and analyze their conditions; and coordinate with providers and community resources to deliver comprehensive health care and support.

We work closely with local community providers, including FQHCs, RHCs, CMHCs, and community agencies. We are working with the Iowa Association of Area Agencies on Aging, the Iowa Behavioral Health Association, the Iowa Disability and Aging Advocates Network (IDAAN), and IowaWorks to explore ways to collaborate for effective service delivery and for communicating with members to improve engagement and outcomes.

STAFFING MODEL

Our staffing model, including Key Personnel identified in RFP SOW Section 2.9.3, encourages a local presence in Iowa, particularly for the delivery of member and provider services. We created a staffing plan based on three plans being awarded with a membership of approximately 195,000 members. By the end of year one we expect to have more than 400 staff in Iowa to support this membership. We anticipate an additional 150 staff to support Iowa in centralized functions, totaling more than 550 staff to support the project overall.

We will have a local presence and confirm that all staff is knowledgeable in Iowa-specific policies and operations through initial and ongoing required training. Staff delivering care coordination services will be based in Iowa at locations that facilitate the delivery of in-person services as appropriate.

The staff proposed in Tables 2-4 will act on an interim basis. We are in the process of recruiting for permanent employees and will provide updates to the Agency within the requested timeframes.

Proposed staff and interim staff

Tables 2-4 and 2-5 list the staffing positions proposed in our staffing plan. With the exception of the Claims administrator, all other required positions will be located in Iowa. Please see Tab 4, Bidder's Background for details on the qualifications of our staff.

Table 2-4: List of proposed staffing positions for key personnel

SOW #	RFP position title	Proposed interim staff name
2.9.3.1	Contract Administrator/CEO	Janet Grant
2.9.3.1	COO	Eileen Shaw
2.9.3.2	Medical Director	Barry Markman, MD (Iowa-licensed)
2.9.3.3	Chief Financial Officer	Deb Bacon
2.9.3.4	Compliance Officer	Patricia Simpson
2.9.3.5	Pharmacy Director/Coordinator	Ted Cummings
2.9.3.6	Grievance & Appeals Manager	Patrice Stevens
2.9.3.7	Quality Management Manager	Kim Herink
2.9.3.8	Utilization Management Manager	Sherry Logan, RN
2.9.3.9	Behavioral Health Manager	Heather Koch
2.9.3.10	Member Services Manager	Michelle Duncan
2.9.3.11	Provider Services Manager	Donette Koehler

SOW #	RFP position title	Proposed interim staff name
2.9.3.12	Information Systems Manager	Rhiannon Yandell
2.9.3.13	Claims Administrator	Colleen Gurule
2.9.3.14	Care Coordination Manager	Kelly DeFrancisco, MSW
2.9.3.15	Program Integrity Manager	To Be Hired
2.9.3.16	Long Term Care Manager	Patricia Wright
2.9.3.17	SIM Grant Liaison	To Be Hired

SUGGESTED STAFFING [SOW 2.9.2]

Table 2-5 outlines our proposed staffing plan.

Table 2-5: Suggested staffing

Suggested staffing	Suggested roles & responsibilities
Prior Authorization & Concurrent Review Staff	Authorize requests for services and conduct inpatient concurrent review.
Member Services Staff	Respond to member inquiries via a member services helpline, as well as written and electronic correspondence.
Provider Services Staff	Respond to provider inquiries and disputes and provide outreach on provider policies and procedures.
Claims Processing Staff	Complete timely and accurate processing of claims.
Reporting and Analytics Staff	Perform timely and accurate reporting and analytics needed to meet the requirements of the Contract.
Quality Management Staff	Perform quality management and improvement activities and oversee health care equity program execution.
Marketing & Outreach Staff	Manage marketing and outreach efforts.
Compliance Staff	Support the Compliance Officer and confirm compliance with Laws and Regulations, internal policies and procedures, and terms of the Contract.
Community-Based Case Managers	Confirm member needs are met, manages resources effectively, and confirm member's health, safety, and welfare is met. Assist the members in gaining access to appropriate resources. Recommend staff have bachelor's degree in social work or related field or commensurate experience. In addition to the Agency's suggested responsibilities, our position will require experience in LTSS, and with members diagnosed with chronic conditions and behavioral health needs.

Attachment 5 – Section 2.9, Question 2

For staffing positions proposed in your staffing plan, provide job descriptions that include the responsibilities and qualifications of the position, including the number of years of experience.

Job descriptions

Table 2-6 on the following page lists job descriptions for staffing positions proposed in our staffing plan, including the responsibilities and qualifications of the position, and number of years of experience required.

Table 2-6: Job Descriptions – CONFIDENTIAL

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]				
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

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Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

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Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]	•	•	•
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

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Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]			

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]	[redacted]		

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Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]				
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]	[redacted]		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

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Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]	[redacted]		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]				
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]	[redacted]		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]			[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

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Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]		[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]	[redacted]		
[redacted]				
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
		[redacted]		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	• [redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]	[redacted]		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]	[redacted]		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]	[redacted]		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]			

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]			

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

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Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]	[redacted]		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	• [redacted]	[redacted]		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
		[redacted]		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
		[redacted]		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]				
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

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Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Position	Responsibilities - CONFIDENTIAL	Qualifications	Number of years' Experience	Education – Certifications - Licenses
	[redacted]	[redacted]	[redacted]	[redacted]

Attachment 5 – Section 2.9, Question 3 [SOW 2.9.3]

Confirm that a final staffing plan, including a resume for each Key Personnel member, will be delivered within ten (10) calendar days after notice of award.

Staffing plan and resumes

Upon award of the Contract, we will deliver the **final** staffing plan within 10 calendar days of the execution of the contract, including **final** resumes for each Key Personnel member

- Our ***proposed*** staffing plan is provided as Table T4-4 in our response to Section 3.2.5.2.1 Tables of organization.
- Resumes for our ***proposed*** interim Key Personnel are provided behind Tab 6, 3.2.7.3 Tab.

Attachment 5 – Section 2.9, Question 4 [SOW 2.9.2, 2.9.4]

Describe your back up personnel plan, including a discussion of the staffing contingency plan for:

In our response to Section 2.9, Question 4 below, we describe our backup personnel plan.

Attachment 5 – Section 2.9, Question 4.a

Discussion of the staffing contingency plan for:

a. The process for replacement of personnel in the event of a loss of Key Personnel or others.

Replacement of personnel and staffing changes [SOW 2.9.1]

We will make good faith efforts to replace personnel and fill vacancies in the event of a loss of key personnel or others within 60 calendar days, unless a different time frame is required by the State, and will obtain State approval of proposed candidates.

Based on our experience, it typically takes more than 60 days to identify and hire an appropriate, qualified candidate, especially in a key personnel position. It is imperative that we take the time to evaluate the knowledge and experience of potential candidates to hire the most qualified person to support the delivery of services under the Contract.

During the recruitment process, we will provide the State with ongoing written updates about our efforts to fill the vacancy. We will not employ a person in a key personnel position without prior approval by the State.

NOTIFYING THE AGENCY OF CHANGES IN STAFFING

We will notify the Agency in writing when changes to key staffing of the Contract occur, including changes in the Key Personnel and other management and supervisory-level staff, at least five business days prior to the last date the employee is employed to the extent possible.

We will provide written notification to the Agency at least 30 calendar days in advance of any plans to change, hire, or re-assign designated Key Personnel. At that time, we will present an interim plan to cover the responsibilities created by the Key Personnel vacancy. Likewise, we will submit the name and resume of the candidate filling a Key Personnel vacancy within 10 business days after a candidate's acceptance to fill a Key Personnel position or 10 business days prior to the candidate's start date, whichever occurs first. We will confirm that knowledge is transferred from an employee leaving a position to a new employee to the extent possible.

EMPLOYER OF CHOICE

Aetna is regarded as an employer of choice:

- Aetna ranked 18th on Barron's 500 List of the Best Companies for 2014
- Fortune magazine added Aetna Chairman and CEO Mark Bertolini to its World's Greatest Leaders list for 2015, which names 50 "singular leaders with vision who moved others to act as well, and who brought their followers with them on a shared quest"
- For the third consecutive year, Aetna was recognized in 2014 as one of the most community-minded companies nationally in the Civic 50 Rankings.
- Aetna ranked first for social responsibility in the Health Care: Insurance and Managed Care category in Fortune magazine's 2015 list of the World's Most Admired Companies.
- In February 2015, Aetna was awarded the National Association of Counties (NACo) Award for Corporate Excellence for its work with NACo to develop strategies for managing the health and well-being of county employees and retirees
- For the eighth year, DiversityInc named Aetna to its 2014 list of Top 50 Companies for Diversity® and ranked Aetna among the top 10 companies for lesbian, gay, bisexual and transgender (LGBT) employees
- The Human Rights Campaign Foundation named Aetna to its 2015 list of Best Places to Work for lesbian, gay, bisexual and transgender (LGBT) employees recognizing Aetna as a company that achieved a perfect score on the 2015 Corporate Equality scale
- For the 16th time, Aetna was named by The National Association of Female Executives (NAFE) as one of the 2015 NAFE Top 50 Companies for Executive Women which highlights companies whose practices identify and promote successful women

We have established a record of success in attracting and retaining high-quality staff at all levels. We have developed aggressive Human Resources strategies that empower us to dramatically enhance the likelihood of filling key positions quickly.

Personnel acquisition begins with the identification of potential candidates for all key positions as well as additional positions that Aetna Better Health deems essential to establishing a well-rounded program. This strategy helps us establish a highly qualified team prepared to meet the day-to-day operational demands of the program.

Attachment 5 – Section 2.9, Question 4.b

Discussion of the staffing contingency plan for:

b. Allocation of additional resources in the event of an inability to meet a performance standard.

Use of additional resources to meet performance standards

If we are unable to meet a performance standard we will allocate additional resources using:

- Experienced Medicaid employees who can be reassigned to a new position to support the Iowa health plan and contract as we reassess our staffing strategy and add permanent staff
- Established business relationships with temporary employment agencies we can hire potential candidates to fill permanent positions

Attachment 5 – Section 2.9, Question 4.c

Discussion of the staffing contingency plan for:

c. Replacement of staff with key qualifications and experience and new staff with similar qualifications and experience.

Replacement of staff

When needed, we will replace staff with key qualifications and experience with new staff who have similar qualifications and experience. Aetna Better Health has two methods for replacing key staff. We have the internal expertise to reassign key personnel, either on a temporary or a permanent basis, to fill any gaps. We also have a dedicated recruiting team who can begin a search for key talent as soon as we become aware of a need for a replacement.

Attachment 5 – Section 2.9, Question 4.d

Discussion of the staffing contingency plan for:

d. The time frame necessary for obtaining replacements.

Timely replacements for staff

The time frame necessary for obtaining replacements for Key Personnel and other staff is 60 days.

Attachment 5 – Section 2.9, Question 4.e [SOW 2.9.7]

Discussion of the staffing contingency plan for:

e. The method of bringing replacement or additions up to date regarding the Contract.

Training new staff – understanding the Iowa High Quality Healthcare Initiative

We provide training to bring replacement or additional staff up to date regarding the Contract. We require new or replacement staff to complete orientation as well as initial and ongoing training specific to their program and position.

Our human resources department maintains an online internal calendar of scheduled training and education sessions. Supervisors of new employees access this calendar to register new and existing staff for training that is specific to the contract, topic, and position.

STAFF TRAINING OVERVIEW

We require our staff to have the education, experience, and training to perform their respective duties. We have a user-friendly, comprehensive training curriculum to accommodate different learning styles. It includes instructor-led classroom sessions, online courses, and on-the-job training. We supplement training by conducting online assessments of staff understanding, knowledge, and retention and offering additional training as needed. We document and maintain training course attendance through our learning management system. We review and update our training curriculum annually, or as changes to our programs, the Agency's requirements, or State and federal laws and regulations occur.

Orientation and initial training: Aetna Better Health orientation and initial training begin upon hire. This initial phase provides new staff with foundational information including:

- Aetna Better Health's organization and internal operations
- An overview of Iowa High Quality Healthcare Initiative and Program
- An overview of the Agency's policies and procedures
- CMS requirements

- Cultural competency and health literacy
- Compliance
- Systems navigation
- Contractual, State, and federal requirements specific to individual job functions

Position-specific training: Upon successful completion of initial training, staff attend training specific to performance of their respective roles. During this phase, new staff must demonstrate knowledge, retention, and understanding of the material covered in the initial training.

Iowa High Quality Healthcare Initiative program: Following completion of position-specific training, we will require staff to attend and participate in Iowa High Quality Healthcare Initiative program training. During this phase, they must demonstrate knowledge, understanding, and retention of the material covered in the initial and position-specific trainings. Program training will familiarize our staff with the diversity needs of our members; the roles and responsibilities of staff; the types of services provided; Waivers; and the challenges facing our members and providers in Iowa. Staff members working with providers receive mentoring and evaluation through on-the-job training at the outset of their service and receive additional training as necessary.

Ongoing training: Staff will participate in mandatory ongoing training, supporting continued compliance, promoting cultural competency and health literacy, and aiding business continuity planning. Quality of care issues, service concerns, member and provider complaints, and Agency program changes resulting in regulatory updates all inform our training curriculum. We determine additional ongoing training needs by trends in business operations; the tracking and trending of issues in specific areas; feedback from managers; and new requirements, policies, or procedures. Ongoing training modalities include instructor-led training sessions, online memo reviews, in-services, e-learning courses, and presentations. Our staff receives periodic electronic training reminders and updates regarding Aetna Better Health's policies and procedures.

Attachment 5 – Section 2.9, Question 5 [SOW 2.9.5, 2.9.6]

Describe which staff will be located in Iowa, and where other staff will be located.

With the exception of the Claims administrator, all other required positions will be located in Iowa.

Staff who will be located in Iowa include:

- Aetna Better Health Contract Administrator/CEO/COO
- Contract Administrator (CEO)
- Chief Operating Officer (COO)
- Medical Director
- Behavioral Health Medical Director
- Chief Financial Officer
- Compliance Officer
- SIM Grant Liaison
- Pharmacy Director/ Coordinator
- Grievance and Appeals Manager
- Quality Management Manager
- Utilization Management Manager
- Behavioral Health Manager
- Member Services Manager
- Provider Services Manager
- Information Systems Manager
- Care Coordination Manager
- Program Integrity Manager
- Long Term Care Manager

Attachment 5 – Section 2.9, Question 5.a [SOW 2.9.6]

a. Describe how out-of-state staff will be supervised to ensure compliance with Contract requirements and how Iowa-based staff shall maintain a full understanding of the operations conducted out-of-state.

Supervision of out-of-state staff

Out-of-state staff will be supervised to confirm compliance with Contract requirements. We have policies, people, and training in place to confirm compliance. Both Iowa-based and out-of-state staff will complete training through our centralized Learning and Performance Department, which will collaborate with Compliance to include Iowa-specific requirements as part of the training. In addition, Iowa-based staff will complete training on various operations we conduct out of state.

Leveraging the support of Aetna affiliates is an approach that has been implemented in all Aetna Medicaid markets. Aetna Medicaid will provide primary support for our Iowa operations. Aetna Life Insurance Company will provide procurement management. Aetna Health Management, LLC will support provider credentialing.

Three Decades of Caring for Those Most Vulnerable

Aetna Medicaid has nearly **30 years of experience** in managing the care of the most vulnerable, using innovative approaches to achieve successful health care results and favorable cost outcomes.

This model of a local, community-based health plan, supported by Aetna Medicaid will benefit our Iowa members threefold, by providing a:

1. Local focus
2. Large fund of knowledge and experience
3. National resource base

Iowa-based staff will maintain a full understanding of the operations conducted out-of-state by participating in initial and ongoing training and regular communication between Aetna Better Health and other cross-functional areas supporting this contract. Iowa-based staff will attend regular cross-functional meetings to share updates with operational groups, such as the Claims Department, who are not based in Iowa.

We will make certain that the location of staff or operational functions outside of the State do not compromise the delivery of integrated services and help to provide a seamless experience for members and providers. Additionally, to verify that location does not hinder the State's ability to monitor our performance and compliance with Contract requirements, we will confirm that all staff functions conducted outside of the State are readily reportable to the Agency at all times.

Attachment 5 – Section 2.9, Question 5.b [SOW 2.9.5]

b. Indicate the location of the Iowa office from which key staff members will perform their duties and responsibilities.

Location of Iowa office

The location of the Iowa office from which key staff members will perform their duties and responsibilities is: 4320 NW 114th St, Urbandale, IA 50322. Further, we provide the:

- **Business location** – We will set up and maintain a business office within the State staffed with the primary contract personnel and managers for the services provided under the Contract.

- **Cost of business location** – We will be responsible for all costs related to securing and maintaining the facility for interim startup support and the subsequent operational facility, including hardware and software acquisition and maintenance, leasehold improvements, utilities, telephone service, office equipment, supplies, janitorial services, security, storage, transportation, document shredders, and insurance.
- **Toll-free communication for offsite activities** – If any activities are approved by the Agency to be performed offsite, then we will provide toll-free communications with Agency staff to conduct business operations.
- **Meeting space for the Agency at our location** – We will provide meeting space to the Agency as requested when onsite at our location. We understand that the Agency will not provide workspace for our staff.

Attachment 5 – Section 2.9, Question 6 [SOW 2.9.7]

Describe your process for ensuring all staff have the appropriate credentials, education, experience and orientation to fulfill the requirements of their position (including subcontractors' staff).

Credentials, education, experience, and orientation of staff

Our process for confirming all staff, including subcontractors' staff, have the appropriate credentials, education, experience, and orientation to fulfill the requirements of their position includes an internal and external job posting and recruiting process that identifies the qualifications, education, experience and job responsibilities required as follows:

- First, an experienced internal recruiting team screens applicants.
- Second, business managers interview those who meet the minimum qualifications for final selection.
- Finally, we require applicants selected for job offers to successfully complete a comprehensive background check to verify information provided regarding their education, employment, and other relevant information. Applicants are also required to successfully pass drug testing before employment.

We are committed to the safety of our members; therefore, an important part of our approach to personnel acquisition is background screening. Upon selection of a candidate to fill a vacancy, we will screen the candidate according to Agency requirements as well as our own internal requirements.

Upon hire, employees complete a corporate orientation program and managers provide departmental and position-specific orientation and training. Managers are responsible for ongoing monitoring and development of employee performance. They confirm their staff meet expectations and provide additional training and coaching as needed.

STAFF ORIENTATION

Once a candidate is hired, we will provide a comprehensive orientation and training program for new personnel. This process includes specific training to reinforce our mission, values, and commitment to high quality, efficient health care. Essential components of our training plan include:

- Providing a comprehensive overview of our workplace culture, including our values, ethics, and dedication to providing an environment focused on our members and providers.
- Providing cultural competency information and training to personnel to address specific cultural and language needs that might challenge the member's ability to access care or understand

healthy practices. We provide an effective health literacy and cultural competency training program as part of our employee orientation.
- Providing training to dispel the myths and stigmas related to disabilities and the negative attitudes often associated with mental illness, HIV/AIDS, and physical and sensorial disabilities.
- Confirming that staff receives training, testing, and a passing score on our mandatory compliance and ethics training, which covers topics such as diversity, HIPAA, Ethical Code of Conduct, and preventing fraud, waste, and abuse.
- Offering job-specific training, including education from experienced staff in a hands-on, laboratory environment; access to job-specific policies, procedures, and helpful resources; and job shadowing.
- Delivering extensive training on technology and systems tools that help staff perform their duties and work efficiently.

Attachment 5 – Section 2.9, Question 7 [SOW 2.9.7]

Describe how you will ensure that all staff is knowledgeable in Iowa-specific policies and operations.

All staff will be knowledgeable in Iowa-specific policies and operations

We will make certain that all staff is knowledgeable in Iowa-specific policies and operations. As described in our response to Attachment 5 – Section 2.9, Question 4.e, all staff will be required to participate in and complete orientation and initial training, position-specific training, Iowa program-specific training, and ongoing training. All staff receive onboarding and job-specific training. Job specific training includes:

- Comprehensive review of all policies and procedures
- Job-specific role play and situational exercises that measure comprehension and application of policies and procedures
- Review of all member and provider facing materials such as the member and provider handbooks, marketing materials, websites, and other tools
- Review of Member and Provider Frequently Asked Questions (FAQ) with practice exercises through role playing and scenario-based testing
- Quality-based training from a member's perspective
- Thorough review of member benefits and community resources
- Completion of an online attestation acknowledging review and understanding of Iowa policies and job-specific procedures.

Attachment 5 – Section 2.9, Question 8 [SOW 2.9.7]

Describe in detail your staff training plans (including subcontractors' staff) and ongoing policies and procedures for training all staff.

Detailed staff training plans

Staff training plans available to our staff and subcontractors' staff include:

- An onboarding training program
- Self-paced learning activities
- Job shadowing
- Instructor-led training and scenario based testing
- E-learning courses available in Aetna's online Learning Management System

- Training vignettes and videos through Aetna Stream, Aetna's online video learning channel

Please see our response to Section 2.9, Question 4e for a description of our staff training overview.

GOALS OF STAFF TRAINING

The goals of staff training will be to:

- Introduce all staff to Iowa policies, procedures, and contract requirements
- Present information regarding member and provider quality
- Teach person-centric, culturally sensitive engagement, and service excellence
- Help staff learn how to manage systems and applications used to perform their job
- Become familiar with job-related end to end work flows and business processes

Each job role has a set of curricula accessible on our Learning and Performance website. The curricula includes a facilitator guide, participant guide, job aids, case scenario packets, final class assessment, access to e-learning materials and all visual learning media such as PowerPoint slides and workflows.

Staff will have a unique training plan based on their position. For example, staff working in specific departments are required to complete a certain number of days of training:

- **Enrollment staff** – up to 15 days of training
- **Operational call center staff** – up to 17 days of training
- **Medical Management staff** – up to 30 days of training
- **Claims Processing staff** – up to 12 weeks of training

Aetna Medicaid supports the concept of lifetime learning and provides ongoing opportunities to for employee development and ever increasing depth of cultural awareness.

Ongoing training for Aetna staff

Ongoing, we verify staff have appropriate credentials, education, experience and orientation to fulfill the requirements of their position. We thoroughly review and verify applicant's credentials, education, and experience against what our job descriptions require. Once hired, we have processes and procedures in place to make sure staff maintain any credentials or licensure required and we provide position-specific initial and ongoing training. Staff will also be required to complete training regarding the major components of this Contract. Aetna Medicaid supports the concept of lifetime learning and provides ongoing opportunities to for employee development and ever increasing depth of cultural awareness.

Training for subcontractors

Our staff and subcontractors are given different levels of access to training resources and the Aetna Learning Management System, an online portal that includes thousands of core classes, vignettes, and training videos. Here, staff can register for mandatory training, request training, or access training related to a specific topic or their job function. The level of training provided to each subcontractor varies and depends on their need to have access to or work with member information. While some subcontractors will be provided training on HIPAA and specific requirements for our Contract with the Agency, others will be required to complete more in-depth training. Our Learning and Performance team monitors and assesses which subcontractors are required to participate in initial and ongoing training. We will verify that all staff working on this contract are adequately trained in order to provide high quality care to members. Staff training will include:

- Contract requirements and State and federal requirements specific to job functions

- In accordance with 42 CFR 422.128, training on the Contractor's policies and procedures on advance directives
- Initial and ongoing training in identifying and handling quality of care concerns
- Cultural sensitivity training
- Training on fraud and abuse and the False Claims Act
- HIPAA training
- Clinical protocol training for all clinical staff
- Ongoing training, at least quarterly, regarding interpretation and application of utilization management guidelines for all utilization management staff
- Assessment processes, person-centered planning and population-specific training relevant to the enrolled populations for all Case Managers
- Abuse, neglect, exploitation, and prevention training, including the detection, reporting, investigation, and remediation procedures and requirements

Training policies and procedures

Our Learning and Performance Department maintains policies and procedures regarding training for all staff. The policies state that:

- The focus of the Learning and Performance Department is to promote contract compliance related to staff training and education
- We will provide training in multiple formats such as:
  - Online Courses
  - Instructor-led training sessions
  - Virtual training solutions
  - Small group activities
  - Technical assistance opportunities
  - Self-study alternatives, optimizing participation in continuing professional as well as personal development
  - On-the-job training with a preceptor

We will also monitor and refine course content to increase effectiveness as well as:

- Conduct and record evaluations of learners' experiences, acquisition of knowledge, skills, and attitudes
- Provide onboarding, initial, and ongoing training for staff and subcontractors to become knowledgeable and skilled in an integrated health care service delivery system
- Complete annual training for employees and subcontractors based on position
- Offer Aetna's Learning Management System, which offers more than 30,000 courses

Aetna Learning Management System

Aetna's learning management system offers more than 30,000 courses as well as monitoring and reporting capabilities for training activities. The Learning Management System is part of the larger Aetna Talent and Reward system managed by Aetna's Learning and Performance Department. Staff can register for and request training online through the Learning Management System; see Figure 2-3. The Talent and Reward system is depicted in Figure 2-2.

Figure 2-2-Aetna Talent / Reward System Home Page

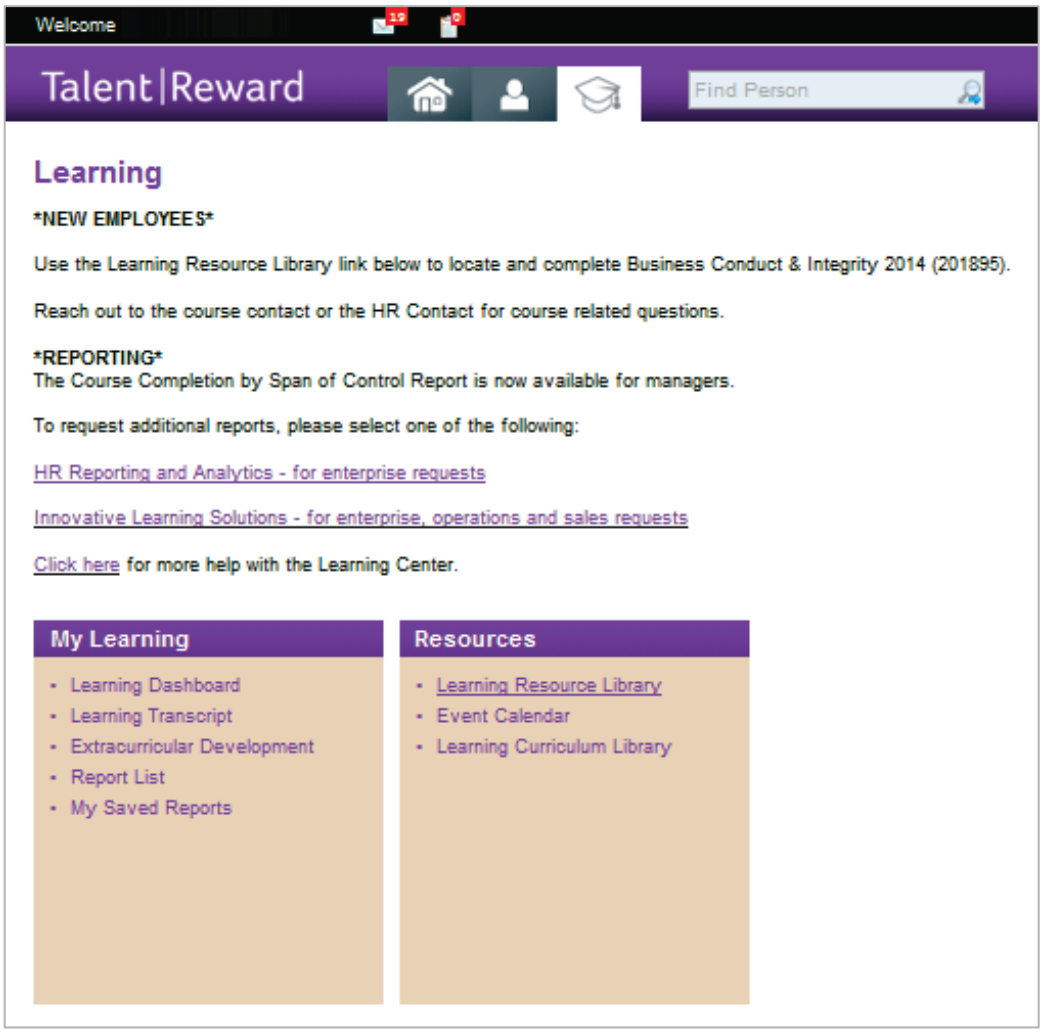


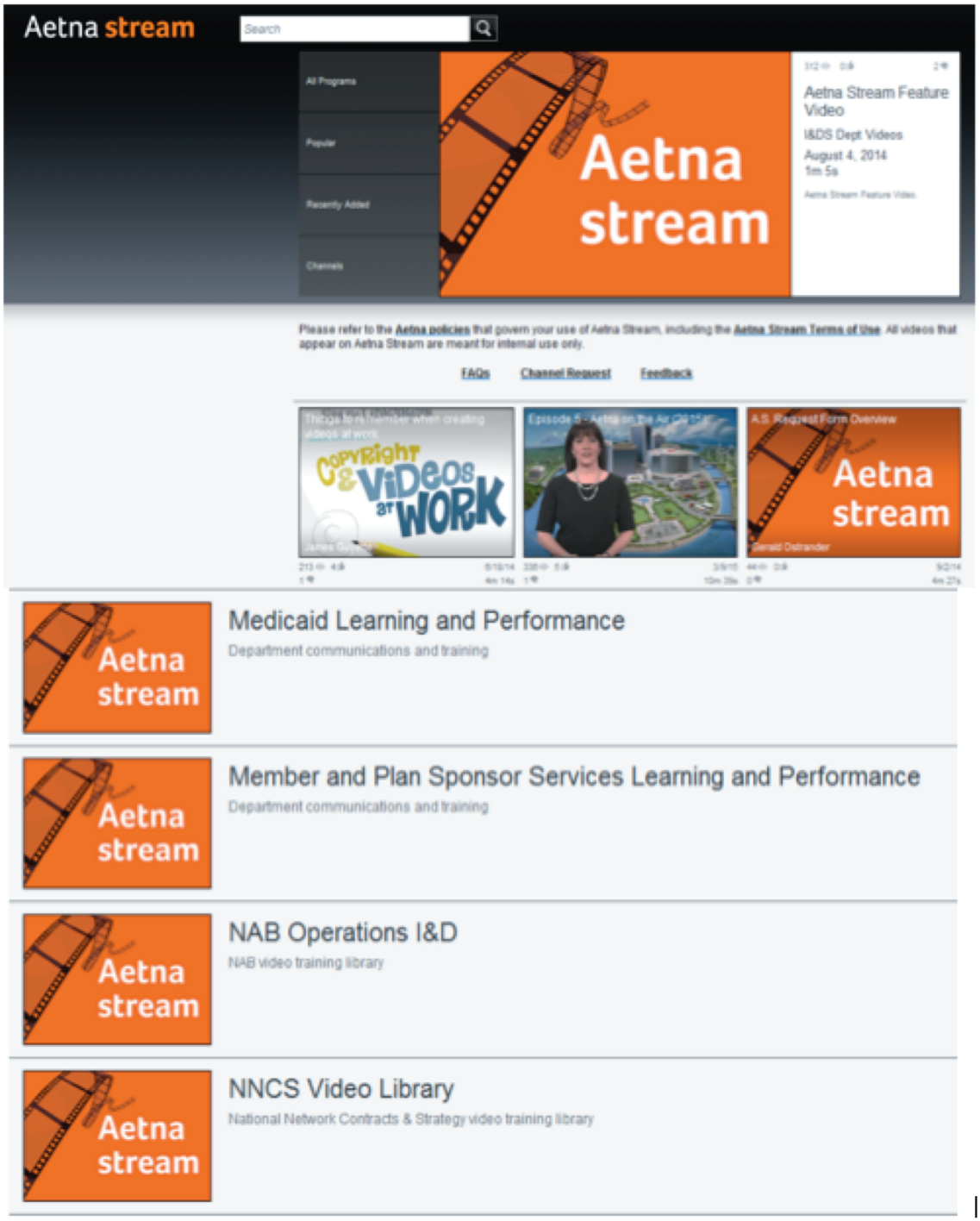
Figure 2-3: Aetna Learning Management System

The Aetna Medicaid Learning and Performance site is structured to teach to different learning styles and levels of health care experience and exposure. The site has a dedicated area for classes specific to Medicaid as displayed in Figure 2-4

Figure 2-4: Medicaid-specific technology based training and videos

Aetna Stream is an online video learning channel. It contains video examples of things like how to use motivational interviewing with a member and can be customized to include Iowa-specific training videos for staff. See Figure 2-5 for screen shots of Aetna Stream.

Figure 2-5: Aetna Stream Home Page - online video learning channel and library



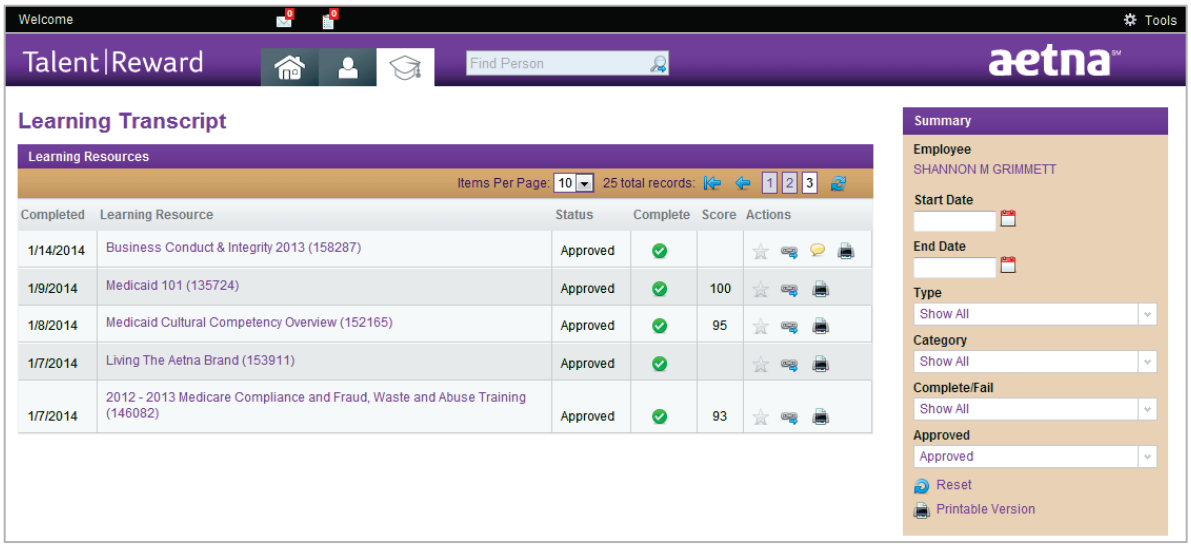
During the readiness review and implementation, we require staff to complete a specific list of trainings and then certify, through our online attestation, depicted in Figure 2-6, they have done so.

Figure 2-6: Staff attestation of completed training

Training transcript: List of completed staff training

Our online Aetna Learning Management System includes a transcript screen. As displayed in Figure 2-7, the transcript shows a list of all instructor-led and technology-based training that has been completed. Any staff member can access this screen to see details including the date their training was completed, the name of training or learning resource, and their score.

Figure 2-7: Learning/Training Transcript – List of Completed Staff Training



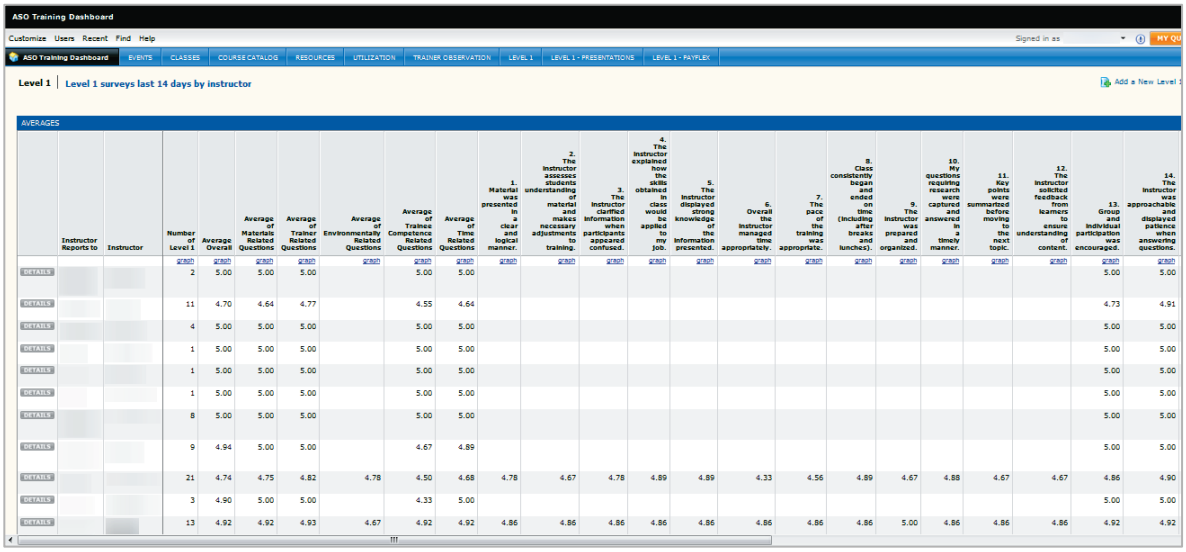
Post training: Learner evaluates the trainer

Post training, staff can fill out an online evaluation to assess how training was for them. There are 30 areas that learners can evaluate the trainer on, with questions including:

- Was the presentation of the material clear and logical?
- Was the pace of the training appropriate?

This enables the Learning and Performance department to measure learners' experiences. They use the reporting and outcomes tools of the evaluation software to continuously improve training.

Figure 2-8: Trainer Evaluation Dashboard



2.11 Coordination with other state agencies and program contractors

Attachment 5 – Section 2.11, Question 1 [SOW 2.11]

Describe how you propose to work with other program contractors, subcontractors, state agencies and third-party representatives.

Working with other state agencies and program contractors

Committed to Health Care Transformation in Iowa

The Agency wants to transform and modernize how high-quality health care services are delivered to members, and so do we. We embrace opportunities to develop relationships with state agencies and other program contractors across Iowa. We take a holistic approach to treating our members and understand the challenges involved in offering the highest levels of care through incorporating community-based agencies. We are in active discussions with over 60 state agencies and program contractors. Figure 2-9 at the end of our response to this question shows many of of the providers and organizations with whom we have had discussions; we will continue to work with these as we implement and operate the Contract.

We will offer a member-centric program and will cooperate and work with other program contractors in areas including the development of policies, processes, and initiatives identified by the Agency intended to improve quality outcomes in the program or streamline provider and member processes. We currently coordinate similar services in many of our other Medicaid contracts. For this contract, we propose to work with other program contractors, subcontractors, state agencies, and third-party representatives such as:

- Iowa Department of Public Health (IDPH) – a critical ally of the Agency and the designated substance use disorder authority for the State of Iowa
- Iowa Department of Education
- Iowa Division of Mental Health and Disability Services
- The Agency of Child Welfare and Juvenile Justice Services
- Ombudsman's Office
- Community Based Agencies, including:
  - Iowa Association of Area Agencies on Aging
  - Iowa Behavioral Health Association,
  - Iowa Disability and Aging Advocates Network (IDAAN), and
  - IowaWorks
- Iowa Department of Inspections and Appeals

Collaboration and coordination with other agencies and contractors

Collaboration and coordination with other state agencies and program contractors is necessary at both the system and member level to support community-based efforts. We will cooperate with other agencies to support member needs, member wellness, and the integration of physical and behavioral health care delivery.

AT THE MEMBER LEVEL

At the member level, we will collaborate with and coordinate between all agencies delivering services. Members and their families are at the heart of each activity and will be able to participate by communicating their strengths, preferences, needs, and individual goals.

Because of multiple funding streams, coordination of benefits between agencies becomes a vital activity that we have experience managing. One type of care could be funded by multiple agencies, which might have resulted in service delays and unmet needs as those agencies "try to work out who will pay," while other services may have few, if any, funding. We eliminate this confusion through management of multiple funding streams, which leads to members getting the care that they need, when they need it. To eliminate the risk of this barrier to care for vulnerable members, inter-agency collaboration is essential during treatment planning and problem solving. It is also important when members experience issues that may affect their housing stability, or when a transition to a different level of service is considered, prompting the need for fluidity between funding agencies.

AT THE SYSTEM LEVEL

At the system level, coordination and collaboration will occur through formal processes such as regularly scheduled ongoing meetings with each agency or program group to discuss the impact of any issues, what is working well, work-flow processes, system problems, and resolutions.

Collaboration will also occur when data-sharing and business associate agreements are prepared, or during multi-system workgroups and committee participation or facilitation.

Collaborative protocols

We will regularly collaborate with other State agencies and program contractors. This is a key element of our efforts to transform and enhance the delivery of services via strong alliances across the entire system through seamless coordination, information sharing, problem solving, and continuous quality improvement. For that reason, we will strive to work cooperatively and collaboratively to provide a delivery system that is fully integrated, patient-centered, and focused on quality. We will demonstrate our commitment through our accessibility, engagement, and follow-through.

We will meet regularly with other State agency and program contractors to identify and resolve issues, overcome barriers, and enhance awareness of goals and needs. These codified collaborations will help improve member care by identifying and providing appropriate resources and services. We also believe that the best outcomes for members start with their very first interaction, which is why we will focus on collaboration with first responders, community allies, jails, court, and State agencies.

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Figure 2-9: Aetna's community-based outreach efforts – **CONFIDENTIAL**

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Attachment 5 – Section 2.11, Question 2

Describe how you propose to work with IDPH related to IDPH-funded substance abuse services.

Coordination with the Iowa Department of Public Health [SOW 2.11.2]

We understand that the IDPH is a critical ally of the Agency, holds authority for IDPH-funded substance use disorder services in this Contract, is the designated substance abuse authority for the state of Iowa, and is responsible for setting substance abuse policy for the State. We have noted that the other programs referenced in the RFP for which IDPH holds authority include local public health services, family planning services, the Iowa Health Information Network, Maternal and Child Health services, and tobacco cessation services.

We will work closely with IDPH throughout the term of the Contract in a manner similar to how we have proposed to work with the other state agencies and program contractors as described in our response to Section 2.11, Question 1.

2.13 Written policies and procedures

Attachment 5 – Section 2.13, Question 1 [SOW 2.13]

Describe your process for developing and maintaining written policies and procedures for each functional area.

Process for developing and maintaining policies and procedures

Aetna Medicaid and Aetna Better Health work together to develop our policies and procedures. Our process for developing and maintaining written policies and procedures, subject to Agency review and approval, for each functional area, includes the following steps:

1. The department responsible for each policy presents the policy to our Policy Committee, which is chaired by our Compliance Officer and includes representatives from each department. The committee reviews each policy, recommends changes, votes to approve, signs, and dates the document. Compliance sends policies and procedures that require State approval to the State.
2. After that, policies are submitted to the Aetna Medicaid Policy Committee for final approval and signature. Approved policies are returned to the health plan for signature by the health plan's Chief Executive Officer and Medical Director.
3. To complete the review cycle, the health plan is required to return an electronic (PDF) copy of the signed policy to the policy committee within 30 days of approval.

AETNA MEDICAID POLICY COMMITTEE – P&P 1501.02

Our internal policy and procedure that governs the Aetna Medicaid Policy Committee states that:

- The Aetna Medicaid Policy Committee is responsible for the oversight of policy development, evaluation, review, revision, and policy approval
- All new policies are evaluated, reviewed, and approved by the Aetna Medicaid Policy Committee prior to execution

POLICY DEVELOPMENT, REVISION, EXECUTION, AND MAINTENANCE – P&P 1501.03

Our internal policy that governs policy development, revision, execution, and maintenance states that:

- All business operating practices and requirements are to be developed, revised, executed, and maintained in accordance with this policy. This is used as a guideline for development of all company policies and procedures.
- Standard policies available to our health plans are based on Aetna Medicaid standard templates and formats and may be modified to maintain compliance with federal laws, State statutes, and the health plan contract.
- Each health plan is responsible for selecting and customizing the standard policies appropriate for their contract-specific requirements.

We review policies and procedures at least annually to make sure they reflect current practice and will be updated as necessary. The Compliance Officer or designated Department Manager is responsible for creating and maintaining review schedules. [SOW 2.13]

If the Agency determines an Aetna Better Health policy requires revision, we will work with the Agency to revise within the timeframes specified. If the Agency determines that we lack a policy or process required to fulfill the terms of the Contract, we will adopt a policy or procedure as directed by the Agency. Upon request, we will provide evidence that all policies and procedures have been fully implemented. [SOW 2.13]

2.14 Participation in readiness review

Attachment 5 – Section 2.14, Question 1

Submit a detailed implementation plan which identifies the elements for implementing the proposed services, including but not limited to:

a. Tasks;
b. Staff responsibilities;
c. Timelines; and
d. Processes that will be used to ensure contracted services begin upon the Contract effective date.

Detailed implementation plan

As Appendix U, we provide a detailed implementation plan that identifies the elements for implementing the proposed services, including:

- Tasks
- Staff responsibilities
- Timelines
- Processes used to verify contracted services begin upon the Contract effective date

To implement the new components of the Initiatives, Aetna Better Health will combine our resources, experience, and expertise with those of our subcontractor, Aetna Medicaid.

The Implementation Plan Summary in Table 2-7 summarizes the activities required to implement this new Contract. Please see Appendix U for our Implementation Plan, a detailed Microsoft Project document that outlines the key activities by function, including associated timeframes.

IMPLEMENTATION PLAN SUMMARY

Table 2-7: Implementation plan summary for new Contract requirements - CONFIDENTIAL

Summary task	Activities	Timeframe
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Implementation approach

GUIDING PRINCIPLES

Implementations are a strategic focus of Aetna Medicaid. Our approach to managing implementations is based on the following guiding principles, which are the foundational strategic directives that drive implementation governance and activity:

- The implementation model follows the overall Aetna Medicaid operating model: Aetna Better Health and Aetna Medicaid are responsible and accountable for the implementation aspects of all functions associated with operational responsibility.
- An empowered Implementation Team will be accountable for each implementation:
  - **Eileen Shaw, Implementation Director**, will serve as the primary point of contact to the Agency and will work with the Agency, the Implementation Lead team, and departmental leadership PMO to successfully execute the project deliverables. Subject Matter Experts (SMEs) and implementation leaders from Aetna Better Health and Aetna Medicaid will support them.
  - Primary governance and execution management of the implementation will be the responsibility of the Implementation Lead Team with leaders from applicable Aetna Better Health and Aetna Medicaid departments.
  - Assigned Implementation Team members will be supported by their departmental leadership, managing deliverables, risks, and issues within their departments as well as within the overall implementation governance model, escalating issues as needed.
  - An Implementation Steering Committee, led by **Aetna Better Health CEO Janet Grant**, oversees the Implementation Lead Team and the implementation to make strategic decisions, manage risk, and address escalated issues.
- The implementation is complete when the new Agency Contract requirements are fully operational.

Guided by these principles, Aetna Better Health and an Aetna team of experienced Medicaid managed care leaders and experts will maintain an effective and efficient integrated care and services model during the implementation period and initial start-up of operations.

IMPLEMENTATION PROGRAM MANAGEMENT AND READINESS

The implementation plan for this Contract confirms that services will begin on the anticipated Contract effective date of January 1, 2016. We have a dedicated organization, dedicated departmental teams, as well as demonstrated practices used to implement new health plan business and programs. Our methods continue to be improved upon through each experience; Aetna Medicaid has launched four new health plans and five new programs in our existing states in the past two years.

Using our resources and experience, Aetna Medicaid has developed four major elements within its overall implementation approach that will help to deliver services for the Initiatives:

1. Implementation Governance and Project Management
2. Implementation Readiness and Requirements Validation
3. System Application Testing
4. Operational Preparedness and Command Center

IMPLEMENTATION GOVERNANCE AND PROJECT MANAGEMENT

Based on Project Management Institute project management methodologies and standard deliverables, Aetna Better Health builds and manages an overall implementation plan, a risk management plan, an issue management practice, a resource plan, and a governance approach.

Our initial implementation plan, presented as Appendix U, is developed using our standard, outcomes-based, new health plan implementation project plan template and updated with specifics from the new Contract's scope of work, contractual and regulatory requirements, and Contract start date. Each department builds their detailed project plan in alignment with the phases, tasks, and deliverables of the overall implementation project plan. They will also determine and assign the resources that are needed.

We conduct a thorough analysis to provide the most reasonable and reliable estimate of full-time equivalent staff and resources needed. We strive to balance reliable guidelines with a realistic view of anticipated progress. Our estimate will consider numerous factors, including productive hours per day, multitasking productivity loss for part-time resources, the number of resources applied to each activity, available working days within the schedule, and calculation of delays and lag times. We also consider the obligations that each staff member has while planning for existing operational Contract requirement needs.

The Implementation Director and Implementation Steering Committee will review and approve the implementation plan. We will also submit this plan to the Agency for review and approval. Our final, approved implementation plan will be used to assign resources and track the usage of those resources and the respective teams' progress towards the implementation milestones. We organize individual teams into sub-groups, which, in turn, collaborate with SMEs as needed to accomplish the actions assigned to them. Our experience shows that this pairing of the sub-groups and the SMEs yields greater efficiency in the use of resources and the completion of assigned tasks.

The Implementation Director and Implementation Lead Team assess the availability of resources by frequently monitoring the implementation plan, weekly status reports, and available outside resources. The team will adjust the implementation plan and resources as appropriate. Throughout implementation, we regularly report on and respond to task dependencies and verify that tasks on the critical path are on track to meet Agency requirements. We manage our implementation plan and update the Implementation Steering Committee through weekly oversight meetings, weekly status reports and dashboards, an issue tracking and escalation log, and updates to our risk management plan for the duration of the project. Additionally, on a bi-weekly basis, and more frequently as we approach the effective date, the overall implementation status is reported to the Aetna Medicaid executive team and our CEO, Pam Sedmak, to address any strategic decision, major risk or critical issue. We will maintain a site on a Microsoft SharePoint server and store all documents related to the implementation on this internal site.

Risk Management Plan

The Aetna Better Health Risk Management Plan is an integral part of the overall project plan. Risks are identified during the risk identification process along with probability of occurrence and possible impact to schedule, quality, and cost. Leveraging our previous implementation experience, factors used in the risk identification process include internal and external sources of risk, such as key resource dependencies and timeliness of requirements. For each significant risk, a risk mitigation and contingency strategy is developed and each risk is monitored and managed throughout the implementation by the Implementation Lead team and the Implementation Steering Committee.

Invariably in every large initiative, issues emerge and are identified that must be assessed and resolved as quickly as possible. Within our issue management approach, all issues are recorded in an issues log on the dedicated Microsoft SharePoint Implementation project web site located on the secure Aetna intranet. Issues are assigned an owner and a level of priority based on impact and severity. High priority

issues are automatically escalated to the Implementation Leadership Team for expedited resolution. Issues that risk the critical path of the implementation schedule, cost, or quality of contracted services are reviewed and managed to resolution through the Implementation Steering Committee and, as necessary, the executive team of Aetna Medicaid.

Implementation readiness and requirements validation

Shortly after the launch of implementation, the Implementation Director, with support from experts in the Aetna Medicaid organization and Project Management Office, will conduct implementation readiness and requirements validation reviews with each department for their implementation deliverables. The review will assess the departmental project plan, risk plan, and resource plan and identify any gaps within those plans to be addressed. Additionally, based on a thorough review of the regulatory and contractual requirements, with a special focus on requirements not fulfilled in our current standard operating model, the review team will validate that service solutions for all requirements are reflected in the individual department work plans and the overall implementation project plan. Any identified requirement delivery gaps will be documented in our issue log and addressed with the department or across the overall implementation project through our standard committee and reporting structure. All gaps will be tracked until they are resolved and meet the contractual and regulatory requirements.

System application testing

Aetna Medicaid follows a rigorous application testing process that incorporates system testing and user acceptance testing into a holistically managed service supported by industry best practices.

The standard types of testing that occur within every implementation are:

- **System testing** – System testing confirms that an application is performing at the expected level based on business requirements and application design.
- **End-to-end testing** – End-to-End testing confirms that accurate data flow occurs between applications and that applications work as expected.
- **Benefit and claims adjudication testing** – These tests are to confirm that the benefits are accurately loaded and associated with the correct types of claims payment.
- **Connectivity and file exchange testing** – Testing performed with the State to confirm site-to-site connectivity as well as the accurate and timely exchange of files.
- **User acceptance testing (UAT)** – User acceptance testing validates that the fully integrated systems are performing correctly and providing the expected business results.

Operational preparedness and Command Center

Operational preparedness is an internal milestone that occurs approximately 60 days before go-live. The intent of operational preparedness is to confirm that all operational and contractual requirements are capable of being delivered before the implementation's effective date.

Operational preparedness activities include:

- Internal review of the requirements captured from the contract
- Validation from each of the supporting areas that requirements are met and have passed testing
- An internal check with Aetna senior leadership that includes formal signoff that all implementation requirements will be achieved prior to the effective date.

COMMAND CENTER – AETNA MEDICAID'S GO-LIVE MONITORING AND SUPPORT

Command Center is Aetna Medicaid's go-live monitoring and support function. Command Center is initially conducted daily with participation from Health Plan leadership, implementation leadership, and key support staff. Each Command Center agenda includes key operational metric reporting, issue tracking or resolution, and plan start-up support monitoring. Command Center meetings continue until the major functions are stable and the plan leadership transitions to standard operational functions. This process confirms that health plan leadership, staff, and operations are managing the health plan functions and responsibilities according to our standard operating model and the contractual and regulatory requirements.

Attachment 5 – Section 2.14, Question 2 [SOW 2.14]

Confirm that you will revise the implementation plan and keep it updated throughout the readiness review process.

Implementation plan updated throughout readiness review

We confirm that we will revise the implementation plan and keep it updated throughout the readiness review process. In contracts such as our recent implementation of services in Louisiana we successfully updated our implementation plan and will do the same for Iowa.

PARTICIPATION IN READINESS REVIEW

We understand that we will undergo and must pass a readiness review process and be ready to assume responsibility for contracted services upon the Contract effective date.

We will maintain a detailed implementation plan that is subject to Agency approval. In addition to submitting the implementation plan with the proposal, we understand that we may be required to submit a revised implementation plan for review as part of the readiness review.

2.15 Confidentiality of member medical records and other information

Attachment 5 – Section 2.15, Question 1 [SOW 2.15]

Describe your plans to ensure that health and enrollment information is used in accordance with the requirements set forth in the Health Insurance Portability and Accountability Act and other applicable federal and state privacy laws and regulations.

We will transmit health and enrollment information securely and process it in accordance with Iowa contractual obligations and HIPAA laws and regulations. We also have internal department policies regarding Protected Health Information (PHI) and HIPAA that abide by Aetna regulations, ensuring that all member information remains secure and compliant.

We have internal policies regarding PHI and HIPAA that abide by Aetna regulations; ensuring member information remains secure and compliant. We provide ongoing training to staff on how to report any potential breach of privacy to our Compliance department.

Member information is secure and used in accordance with HIPAA

We tailor our information technology solutions for services in 17 states. Our centralized, HIPAA-compliant, client/server-based managed care information systems containing health and enrollment information will be used in accordance with the requirements set forth in HIPAA and other applicable

federal and State privacy laws and regulations. We comply with all aspects of HIPAA and will do so for Iowa. All information regarding our members, including eligibility or identification information, will be kept secure and HIPAA compliant.

ELECTRONIC CASE MANAGEMENT SYSTEM

Information stored and tracked in our electronic case management system is HIPAA Compliant. For a more detailed description, please see our response to Section 13.1, Question 7.

DATA EXCHANGE

We describe our HIPAA-compliant data exchange processes for verifying member enrollment in detail in our response to Section 13.3. We can receive a HIPAA-compliant 834 enrollment file from the State and confirm health and enrollment information will be used in accordance with HIPAA requirements.

STANDARDS AND AUDITS

Our Information Security Policy is based on the following supporting national standards:

- **HIPAA** (Health Insurance Portability and Accountability Act of 1996)
- **ISO/IEC 27002:2005** International Organization for Standardization; Information Technology - Security Techniques - Code of Practice for Information Security Management
- **PCI DSS 2.0** Payment Card Industry Data Security Standards v2.0; Payment Card Security Requirements

We conduct the following industry standard audits of our information security systems to test and maintain information integrity:

- Service Organization Controls - SOC -1; semi-annually (SAS-70 replacement)
- Sarbanes Oxley (SOX); annually
- HIPAA risk assessment; annually (Health Information Portability and Accountability Act)
- Internal Audits; throughout the year
- Payment Card Industry (PCI); annually
- Penetration & Vulnerability Testing; throughout the year

Aetna Better Health will provide the Agency a quarterly Privacy/Security Incident Report. The report will include incident scope, our response, and mitigating measures.

We will develop, implement, and adhere to written policies and procedures, subject to Agency review and approval, pertaining to maintaining the confidentiality of all medical records and other pertinent information, including health and enrollment information.

In accordance with 42 CFR 438.224, we confirm that member medical records, as well as any other health and enrollment information that contains individually identifiable health information, is used and disclosed in accordance with the privacy requirements set forth in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (see 45 CFR parts 160, 162 and 164, subparts A and E) including confidentiality of family planning services.

We will also comply with all other applicable State and federal privacy and confidentiality requirements. We will protect and maintain the confidentiality of mental health information by implementing policies for staff and through contract terms with network providers, which allow release of mental health information only as allowed by Iowa Code §228.

Further, we will protect and maintain the confidentiality of substance use disorder information, allowing the release of substance use disorder information only in compliance with policies set forth in 42 CFR Part 2 and other applicable state and federal law and regulations.

We will notify the Agency of any HIPAA-related breach in accordance with the terms of Section 1.5 of the Contract's Special Terms. We will notify the Agency within one business day upon discovery of a non-HIPAA-related breach.

2.16 Material change to operations

Attachment 5 – Section 2.16, Question 1 [SOW 2.16]

Describe how you will inform DHS in advance of any material changes, and how far in advance DHS will be informed.

Informing the Agency of material changes

We will inform the Agency in advance of any material changes through written notification and communicating any changes verbally, either telephonically or as part of regular meetings with the Agency. Aetna will inform the Agency of material changes in the period applicable but no less than 30 days before the effective date of the change.

Material change to operations

Before implementing a material change in operation, we will notify the Agency. The notification will contain, at minimum:

- Information regarding the nature of the change
- Rationale for the change
- Proposed effective date
- Sample member and provider notification materials

Attachment 5 – Section 2.16, Question 2 [SOW 2.16]

Confirm that DHS may deny or require modification to proposed material changes if, in its sole discretion, it determines that such changes will adversely impact quality of care or access.

Modification to proposed material changes

We confirm that the Agency may deny or require modification to proposed material changes if, at its sole discretion, it determines that such changes will adversely impact quality of care or access. We will always confirm that quality of care will not be impacted by material changes.

Attachment 5 – Section 2.16, Question 3 [SOW 2.16]

Describe your ability to communicate material changes to members or providers at least thirty (30) days prior to the effective date of the change.

Methods to notify both members and providers about material changes

We will communicate material changes to members and providers at least 30 days prior to the effective date of the change. Changes can be communicated through various methods including mailers, updates to member or provider handbooks, blast faxes to providers, and website updates. Our communication strategies will include the following:

- **Aetna Better Health's website** – The website will include the most up-to-date information for members and providers. The quarterly Member Newsletter, along with the Member Handbook, Provider Directory, and other important information, will also be available on the website.
- **Social media postings** – We will use multiple social media outlets, based on feedback from our members and the community to keep members and providers up to date.
- **Targeted mailings** – We will use targeted mailings to communicate regarding material changes. These mailings will also explain how we will deliver care and services to our members.
- **Member newsletters** – These quarterly communications will contain general information on prevention and wellness. We will use a professional newsletter publishing company to prepare our member newsletters.
- **Program brochures and flyers** – We will distribute specific and targeted information regarding material changes as appropriate.

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Section 3: Scope and Covered Benefits

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SECTION 3 – SCOPE AND COVERED BENEFITS

The table below outlines how the Scope of Work provided in RFP Attachment 1 relates to the responses to the questions provided in RFP Attachment 5. We provide this table to reduce redundancy of responses and information and to simplify the evaluation process for the evaluators.

For requirements in Attachment 1 that do not require a detailed response, the table below indicates our intent to comply with the stated requirement in lieu of repeating the RFP question and including a will comply statement within the body of the narrative.

Attachment 1 requirement	Cross-reference to Attachment 5	Will comply
3.1 Scope	--	Yes
3.1.1 Eligible Members	--	Yes
3.1.1.1 Iowa Department of Public Health Participants	--	Yes
3.1.1.2 Excluded Populations	--	Yes
3.1.2 Effective Date of Contractor Enrollment	--	Yes
3.1.3 Geographic Service Area	--	Yes
3.2 Covered Benefits	--	Yes
3.2.1 General	Attachment 5 – Section 3.2.2, Question 2	Yes
3.2.2 Benefit Packages	Attachment 5 – Section 3.2.2, Question 1	Yes
3.2.2.1 Iowa Health and Wellness Plan	Attachment 5 – Section 3.2.2, Question 1	Yes
3.2.2.2 Family Planning Network	Attachment 5 – Section 3.2.2, Question 1	Yes
3.2.2.3 Presumptively Eligible Pregnant Women	Attachment 5 – Section 3.2.2, Question 1	Yes
3.2.2.4 Children's' Health Insurance Plan (CHIP) and hawk-i	Attachment 5 – Section 3.2.2, Question 1	Yes
3.2.2.5 Other	Attachment 5 – Section 3.2.2, Question 1	Yes
3.2.3 Changes in Covered Services	Attachment 5 – Section 3.2.2, Question 2	Yes
3.2.4 Integrated Care	Attachment 5 – Section 3.2.4, Question 1	Yes
3.2.5 Emergency Services	Attachment 5 – Section 3.2.5, Question 2	Yes
3.2.5.1 Review of Emergency Claims	Attachment 5 – Section 3.2.5, Question 4	Yes
3.2.5.2 Claim Coverage	Attachment 5 – Section 3.2.5, Question 4	Yes
3.2.5.3 Member Liability	--	Yes
3.2.5.4 Post-Stabilization Services	Attachment 5 – Section 3.2.5, Question 2	Yes
3.2.5.5 Emergency Room Utilization Management	Attachment 5 – Section 3.2.5, Question 1	Yes
3.2.6 Pharmacy Services	--	Yes
3.2.6.1 Covered Services	Attachment 5 – Section 3.2.6, Question 1	Yes
3.2.6.1.1	Attachment 5 – Section 3.2.6, Question 1	Yes
3.2.6.1.2	--	Yes
3.2.6.1.3	--	Yes
3.2.6.2 Pharmacy Preferred Drug List (PDL) and Recommended Drug List (RDL)	--	Yes
3.2.6.2.1 Preferred Drug List (PDL)	--	Yes
3.2.6.2.1.1	--	Yes
3.2.6.2.1.2	--	Yes
3.2.6.2.1.3	--	Yes
3.2.6.2.2 Recommended Drug List (RDL)	--	Yes
3.2.6.2.2.1	Attachment 5 – Section 3.2.6, Question 1	Yes

Attachment 1 requirement	Cross-reference to Attachment 5	Will comply
3.2.6.2.2.2	Attachment 5 – Section 3.2.6, Question 1	Yes
3.2.6.3	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.1	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.2	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.3	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.3.1	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.3.2	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.3.3	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.3.4 Reserved	--	Yes
3.2.6.3.3.5	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.3.6	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.3.7	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.3.8	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.3.9	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.3.10	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.3.11	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.4	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.4.1	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.4.2	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.4.3	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.4.4	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.4.4.1	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.4.4.2	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.4.4.3	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.4.4.4 Reserved	--	Yes
3.2.6.3.4.4.5	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.4.4.6	Attachment 5 – Section 3.2.6, Question 4	Yes
3.2.6.3.4.4.7 Reserved	--	Yes
3.2.6.4	Attachment 5 – Section 3.2.6, Question 6	Yes
3.2.6.4.1	Attachment 5 – Section 3.2.6, Question 6	Yes
3.2.6.4.1.1	Attachment 5 – Section 3.2.6, Question 6	Yes
3.2.6.4.2	Attachment 5 – Section 3.2.6, Question 6	Yes
3.2.6.4.3	Attachment 5 – Section 3.2.6, Question 6	Yes
3.2.6.4.4	Attachment 5 – Section 3.2.6, Question 6	Yes
3.2.6.4.5	Attachment 5 – Section 3.2.6, Question 6	Yes
3.2.6.5 Utilization Management	--	Yes
3.2.6.5.1	Attachment 5 – Section 3.2.6, Question 6	Yes
3.2.6.5.2	Attachment 5 – Section 3.2.6, Question 6	Yes
3.2.6.5.2.1	Attachment 5 – Section 3.2.6, Question 6	Yes
3.2.6.5.2.2	Attachment 5 – Section 3.2.6, Question 6	Yes
3.2.6.5.2.3	Attachment 5 – Section 3.2.6, Question 6	Yes
3.2.6.5.2.4	--	Yes
3.2.6.6 Pharmacy Network, Access Standards and Reimbursement	--	Yes
3.2.6.6.1	Attachment 5 – Section 3.2.6, Question 1	Yes

Attachment 1 requirement	Cross-reference to Attachment 5	Will comply
3.2.6.6.1.1	Attachment 5 – Section 3.2.6, Question 5	Yes
3.2.6.6.1.2	--	Yes
3.2.6.6.1.3	Attachment 5 – Section 3.2.6, Question 1	Yes
3.2.6.6.1.4	Attachment 5 – Section 3.2.6, Question 1	Yes
3.2.6.6.1.5	Attachment 5 – Section 3.2.6, Question 5	Yes
3.2.6.6.1.5.1	Attachment 5 – Section 3.2.6, Question 5	Yes
3.2.6.6.1.5.2	Attachment 5 – Section 3.2.6, Question 5	Yes
3.2.6.6.1.5.3	Attachment 5 – Section 3.2.6, Question 5	Yes
3.2.6.6.1.5.4	--	Yes
3.2.6.6.1.5.5	--	Yes
3.2.6.6.1.5.6	--	Yes
3.2.6.6.1.5.7	--	Yes
3.2.6.6.1.5.8	--	Yes
3.2.6.7 Pharmacy Network	--	Yes
3.2.6.7.1	Attachment 5 – Section 3.2.6, Question 1	Yes
3.2.6.7.2	Attachment 5 – Section 3.2.6, Question 1	Yes
3.2.6.8 Pharmacy Access	Attachment 5 – Section 3.2.6, Question 1	Yes
3.2.6.8.1	--	Yes
3.2.6.8.2	--1	Yes
3.2.6.9	Attachment 5 – Section 3.2.6, Question 1	Yes
3.2.6.9.1 Drug Ingredient Reimbursement:	--	Yes
3.2.6.9.1.1	--	Yes
3.2.6.9.1.2 Reserved	--	Yes
3.2.6.9.2 Pharmacy Dispensing Fee	--	Yes
3.2.6.9.2.1	--	Yes
3.2.6.9.3 340B: Drug Pricing Program	--	Yes
3.2.6.9.3.1	--	Yes
3.2.6.9.3.1.1	--	Yes
3.2.6.9.3.1.2	--	Yes
3.2.6.9.4 340B	--	Yes
3.2.6.10 Drug Rebates	--	Yes
3.2.6.10.1	--	Yes
3.2.6.10.2	--	Yes
3.2.6.10.3	--	Yes
3.2.6.11 Pharmacy Encounters Claims Submission	--	Yes
3.2.6.11.1	Attachment 5 – Section 3.2.6, Question 1	Yes
3.2.6.11.2	Attachment 5 – Section 3.2.6, Question 1	Yes
3.2.6.11.3	--	Yes
3.2.6.11.4	--	Yes
3.2.6.12 Disputed Pharmacy Encounter Submissions	--	Yes
3.2.6.12.1	--	Yes
3.2.6.12.2	--	Yes
3.2.6.12.3	--	Yes
3.2.6.12.4	--	Yes
3.2.7 EPSDT Services	Attachment 5 – Section 3.2.7, Question 1	Yes

Attachment 1 requirement	Cross-reference to Attachment 5	Will comply
3.2.7.1 Screening, Diagnosis and Treatment	Attachment 5 – Section 3.2.7, Question 1	Yes
3.2.7.2 Reports and Records	Attachment 5 – Section 3.2.7, Question 2	Yes
3.2.7.3 Outreach	Attachment 5 – Section 3.2.7, Question 2	Yes
3.2.8 Behavioral Health Services	Attachment 5 – Section 3.2.8, Question 1	Yes
3.2.8.1 Philosophy in the Design & Delivery of Behavioral Health Services and Supports	Attachment 5 – Section 3.2.8, Question 2	Yes
3.2.8.2 Rehabilitation, Recovery and Strengths-Based Approach to Services	Attachment 5 – Section 3.2.8, Question 1	Yes
3.2.8.3 Active Engagement Strategy for Families	Attachment 5 – Section 3.2.8, Question 3	Yes
3.2.8.4 Individual Service Coordination and Treatment Planning Requirements	Attachment 5 – Section 3.2.8, Question 1	Yes
3.2.8.5 Scope of Covered Mental Health Services	--	Yes
3.2.8.6 Scope of Covered Substance Use Disorder Services	--	Yes
3.2.8.7 Iowa Health and Wellness Plan	--	Yes
3.2.8.8 Peer Support/Counseling	Attachment 5 – Section 3.2.8, Question 4	Yes
3.2.8.9 Integrated Mental Health Services and Supports	Attachment 5 – Section 3.2.8, Question 9	Yes
3.2.8.10 Prevention and Early Intervention	Attachment 5 – Section 3.2.8, Question 5	Yes
3.2.8.11 Court-Ordered Mental Health Services	--	Yes
3.2.8.12 Court-Ordered Substance Use Disorder Services	--	Yes
3.2.8.13 Services at a State Mental Health Institute	--	Yes
3.2.8.13.1 For Members Under Age 21 or 65 and Older	--	Yes
3.2.8.13.2 For Members Over Age 21 and Under Age 65	--	Yes
3.2.8.14 Pregnant Women that have a Substance Use Disorder	--	Yes
3.2.8.15 Outreach Services for IV Drug Users	Attachment 5 – Section 3.2.8, Question 6	Yes
3.2.8.16 Tuberculosis Services	Attachment 5 – Section 3.2.8, Question 6	Yes
3.2.8.17 Evidence-Based Coverage	--	Yes
3.2.8.18 Services for Children with Serious Behavioral Health Conditions	--	Yes
3.2.8.19 Reserved		Yes
3.2.8.20 Parity	Attachment 5 – Section 3.2.8, Question 9	Yes
3.2.8.21 Behavioral Health, Substance Use Disorder, and Physical Health Integration	Attachment 5 – Section 3.2.8, Question 10	Yes
3.2.9 Health Homes	Attachment 5 – Section 3.2.9, Question 1	Yes
3.2.9.1 Integrated Health Homes	Attachment 5 – Section 3.2.9, Question 1	Yes
3.2.9.1.1 Clinical and Care Coordination Support	Attachment 5 – Section 3.2.9, Question 1	Yes
3.2.9.1.2 Learning Activities	Attachment 5 – Section 3.2.9, Question 1	Yes
3.2.10 Chronic Condition Health Homes	Attachment 5 – Section 3.2.10, Question 1	Yes
3.2.11 1915(i) Habilitation Program Services and 1915(c) Children's Mental Health (CMH) Services	Attachment 5 – Section 3.2.11, Question 1	Yes
3.2.11.1 Initial Determination for Non-Members	Attachment 5 – Section 3.2.11, Question 1	Yes

Attachment 1 requirement	Cross-reference to Attachment 5	Will comply
3.2.11.2 Level of Care and Needs Based Eligibility Assessments and Annual Support Assessments	Attachment 5 – Section 3.2.11, Question 1	Yes
3.2.11.2.1 Identification	Attachment 5 – Section 3.2.11, Question 1	Yes
3.2.11.2.2 Initial Assessment and Annual Support Assessment	Attachment 5 – Section 3.2.11, Question 1	Yes
3.2.11.2.3 Documentation Requirements	--	Yes
3.2.11.2.4 Appearance of Ineligibility	--	Yes
3.2.11.2.5 Waiting List	--	Yes
3.2.11.2.6 Service Plan Development	Attachment 5 – Section 3.2.11, Question 1	Yes
3.2.11.2.7 Frequency	Attachment 5 – Section 3.2.11, Question 1	Yes
3.2.11.2.8 Person-Centered Planning Process	Attachment 5 – Section 3.2.11, Question 1	Yes
3.2.11.2.8.1	--	Yes
3.2.11.2.8.2	--	Yes
3.2.11.2.8.3	--	Yes
3.2.11.2.8.4	--	Yes
3.2.11.2.8.5	--	Yes
3.2.11.2.8.6	--	Yes
3.2.11.2.8.7	--	Yes
3.2.11.2.8.8	--	Yes
3.2.11.2.8.9	--	Yes
3.2.11.2.8.10	--	Yes
3.2.11.2.8.11	--	Yes
3.2.11.2.8.12	--	Yes
3.2.11.2.9 Emergency Plan Requirements	--	Yes
3.2.11.2.10 Home-Based Habilitation	Attachment 5 – Section 3.2.11, Question 1	Yes
3.2.11.2.11 Refusal to Sign	--	Yes
3.2.11.2.12 Compliance with Home and Community-Based Setting	--	Yes
3.2.11.2.13 Disenrollment	--	Yes
3.2.11.2.14 Minimum Service Requirements	--	Yes
3.2.11.2.15 Frequency of Care Coordination Contact	--	Yes
3.2.11.2.16 Monitoring Receipt of Services	Attachment 5 – Section 3.2.11, Question 1	Yes
3.2.12 Family Planning Services		Yes
3.2.13 Iowa Health and Wellness Plan Benefits	Attachment 5 – Section 3.2.13, Question 1	Yes
3.2.13.1 Medically Exempt	--	Yes
3.2.13.1.1 Identification of Medically Exempt Members	Attachment 5 – Section 3.2.13, Question 2	Yes
3.2.13.1.2 Benefits for Medically Exempt Members	--	Yes
3.2.14 Value-Added Services	Attachment 5 – Section 3.2.14, Question 1	Yes
3.2.14.1 Applicability	Attachment 5 – Section 3.2.14, Question 1	Yes
3.2.14.2 Costs	Attachment 5 – Section 3.2.14, Question 1	Yes
3.2.14.3 Program Description	Attachment 5 – Section 3.2.14, Question 1	Yes
3.2.14.4 Approval & Implementation of Value-Added Services	Attachment 5 – Section 3.2.14, Question 1	Yes
3.2.15 Administration of Covered Benefits	--	Yes
3.2.15.1 Medical Necessity Determinations	--	Yes

Attachment 1 requirement	Cross-reference to Attachment 5	Will comply
3.2.15.2 Second Opinions	--	Yes
3.2.15.3 Cost Sharing and Patient Liability	--	Yes
3.2.16 Physician Administered Drugs	--	Yes
3.3 Continuity of Care	--	Yes
3.3.1 Prior Authorizations	Attachment 5 – Section 3.3, Question 1	Yes
3.3.2 Transition Period - Out-of-Network Care	Attachment 5 – Section 3.3, Question 1	Yes
3.3.3 Transitions during Inpatient Stays	Attachment 5 – Section 3.3, Question 1	Yes
3.3.4 Long Term Services and Supports (LTSS)	Attachment 5 – Section 3.3, Question 1	Yes
3.3.5 Residential Services	--	Yes
3.3.5.1 Year One Operations	--	Yes
3.3.5.2 Ongoing Operations	--	Yes
3.3.6 Pregnancy Continuity of Care	--	Yes
3.3.7 Dual Diagnosis Continuity of Care	--	Yes
3.4 Coordination with Medicare	Attachment 5 – Section 3.4, Question 1	Yes

3.1 Scope (SOW 3.1.1, 3.1.1.1, 3.1.1.2, 3.1.2, 3.1.3)

Please explain how you propose to execute Section 3 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Three Decades of Caring for Those Most Vulnerable

Aetna Medicaid Administrators (Aetna Medicaid*) has been a leader in Medicaid managed care since 1986 and currently serves nearly 3 million members in 17 states. Aetna Medicaid has ***30 years of experience in managing the care of the most vulnerable***, using innovative approaches to achieve successful health care results and optimal cost outcomes. Aetna Medicaid manages Medicaid managed care health plans for affiliated Aetna health plans as well as unaffiliated third-party health plans that serve a full range of Medicaid members. Aetna Better Health will hold the managed care contract for Iowa. If awarded the Contract in Iowa, Aetna Medicaid will provide plan management services to Aetna Better Health, pursuant to an intercompany administrative services agreement. As described throughout this section, we have had many successes throughout our extensive experience covering TANF, CHIP, Long Term Services and Supports (LTSS), dual-eligible members, individuals with behavioral health needs, developmentally disabled adults and children, children with special health care needs, and those covered by waivers in these states.

In this Scope of Work, we will highlight our success in delivering exceptional performance in integrated care, emergency services; pharmacy services; Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services; behavioral health services health homes; Habilitation Program and Children's Mental Health (CMH) services; Iowa Health and Wellness Plan benefits; continuity of care; and coordination with Medicare.

Over the past several months, we have crisscrossed Iowa to meet with key hospital system executives, community agencies and other stakeholders across Iowa to understand what is working well and how our experience and solutions can bring immediate value to members, providers, and the State. The map in Figure 3-1 illustrates just a small sample of the providers with whom we have met.

* Aetna Medicaid is composed of Aetna Medicaid Administrators LLC, along with its affiliates that support the organization's Medicaid operations.

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The result of these conversations is a customized approach to how we will enhance existing services in Iowa, including:

- ***Matching eligibility to benefits through system applications and care coordination.***
- Building a ***comprehensive, integrated, provider network*** focusing on areas with a high concentration of current and potential members
- Delivering fully integrated care using our ***Integrated Care Management (ICM) program.***
- Collaborating with members and providers to ***reduce inappropriate Emergency Department (ED)*** use through the use of ***predictive modeling and provider incentives***
- Managing pharmacy benefits with a Head of Pharmacy who is ***licensed in the state of Iowa***
- Detecting quality through ***prospective and retrospective Drug Utilization Review*** compliant with federal law
- Bringing our EPSDT best practices to Iowa's "Care for Kids." Across Aetna Medicaid, we have multiple health plans ***above the National 90th percentile for HEDIS® (registered trademark of NCQA) 2014 EPSDT*** measures
- Delivering exceptional person-centered behavioral health services and supports. For over 25 years, our plan in Arizona has been ***one of the country's first to promote behavioral and physical health care integration***
- Supporting and expanding Iowa Health Homes and Integrated Health Homes with our provider network, value-based solutions, and our ICM program
- Supporting Iowa's HCBS Habilitation Program and CMH waiver services
- Transitioning and caring for Medically Exempt members
- ***Offering value-added services*** that encourage and support Iowans on a path to greater health
- Determining ***medical necessity to support appropriate cost-effective care***
- Transitioning members through proven compassionate and efficient care transition strategies
- Providing care coordination strategies for dual-eligible members

In Delaware, we have transitioned 12,000 high-risk, special health need members into our plan within in a few weeks when another contractor terminated its contract with a children's hospital.

In Kentucky, we brought on 68,000 members immediately when the outgoing plan terminated.

We will discuss detail on how we achieved these successes throughout this section, as well as provide cross-references where the reader may find more detailed information in other sections of the RFP.

3.2 Covered benefits

3.2.1 General

The Contractor shall provide, at minimum, all benefits and services deemed medically necessary services that are covered under the Contract with the State. In accordance with 42 CFR 438.210(a)(3), the Contractor must furnish covered services in an amount, duration and scope reasonably expected to achieve the purpose for which the services are furnished. The Contractor may not arbitrarily deny or reduce the amount, duration and scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary. The Contractor may place appropriate limits on a service on the basis of medical necessity criteria for the purpose of utilization control, provided the services can reasonably be expected to achieve their purpose. Further information on allowable and required utilization control measures is outlined in Section 11. The Contractor shall not avoid costs for services covered in the Contract by referring members to publicly supported health care resources. The Contractor shall not deny reimbursement of covered services based on the presence of a pre-existing condition. The Contractor shall allow each enrollee to choose his or her health professional to the extent possible and appropriate.

Medically necessary services are covered

Aetna Better Health will provide all covered medical services, behavioral health services, and ancillary services included in the program to each enrolled member beginning on the effective date of coverage for the member and on the Contract start date after Contract execution with the Agency.

We will provide all medically necessary covered services according to the individual needs of each member. Medical necessity is assessed by using nationally recognized clinical guidelines for behavioral and physical health and Aetna Clinical Policy Bulletins. We understand and will follow medically necessary services per 42 CFR 438.210(a)(3) and our internal LTSS guidelines. We discuss this in more detail in 3.2.15.1 and Section 11.

Members not referred to public health care resources

We recognize our responsibility for and stewardship to the members enrolled with our plan to cover their medical needs. We will not refer our members to publically supported health care resources for their medical needs in lieu of providing and paying for covered services.

Pre-existing conditions are not excluded

We understand that pre-existing conditions are not excluded and will follow this requirement.

3.2.2 Benefit packages

Attachment 5 – Section 3.2.2, Question 1 (SOW 3.2.2.1, 3.2.2.2, 3.2.2.3, 3.2.2.4, 3.2.2.5, 3.2.3)

Describe your proposed approach to ensure benefit packages will be delivered in accordance with a member's eligibility group.

HOW OUR SYSTEM WILL SUPPORT BENEFIT DELIVERY IN IOWA

Quality and Value through Simple, Relevant Solutions

Aetna Better Health has the systems tools and capabilities to adhere to the benefit requirements in Attachment 1 to the RFP, Section 3.2.2. We maintain an IT infrastructure that is reliable, flexible, and designed to make certain that member benefits

are delivered per their eligibility group. These systems support member services, care management, claims processing, and other functions needed to aid Iowa-specific community services.

At the core of our application architecture is our centralized HIPAA-compliant claims adjudication system. Our configuration includes 28 integrated modules that maintain and process health care administration data, allowing us to increase administrative efficiency and improve the quality of care. This rules-based, information-integrated processing system:

- Adjudicates claims per member eligibility group and medical necessity requirements
- Expands to meet changes in covered services or membership
- Manages benefit package differences in the categories of assistance, program status code, age, and other insurance (for example, Medicare coverage)
- Provides support for all other business applications in the aspects of care monitoring, delivery, and reporting, such as wellness and EPSDT
- Manages claims adjudication, payment, coordination of benefits (COB), and third-party liability (TPL)
- Manages demographic and enrollment data, including prior coverage data
- Manages provider contract data, including reimbursement agreements, provider demographics, and contract terms
- Manages prior authorization and special needs data
- Supports Electronic Data Interchange (EDI)
- Maintains Medicaid eligibility records to support Utilization Management (UM) through Prior Authorizations (PAs) and concurrent reviews

CHANGES IN COVERED SERVICES

Our change and release management process provides a structured, fully recoverable framework in which to implement and manage releases of system changes in accordance, and on schedule, with federal, Agency, and Contract-specific requirements. Our implementation schedule for the Agency currently provides full conformity with federal and Agency-specific standards. Small projects and enhancements have ad hoc releases, while large project releases are driven by regulatory mandates or business needs. These changes get communicated throughout the organization to include care management and member services. We communicate changes externally to our members and providers.

Attachment 5 – Section 3.2.2, Question 2 (SOW 3.2.2, 3.2.3)

Describe your ability to provide covered benefits and services.

Three Decades of Caring for Those Most Vulnerable

Aetna Better Health will use the experience gained in our health plans to deliver tailored service coordination and exceptional customer service to members, caregivers, and providers. Aetna Medicaid has particular expertise in serving the most vulnerable Medicaid populations.

BUILDING A PROVIDER NETWORK

Aetna Inc. has been operating in Iowa since 1985, and our Iowa health plan today serves over 178,000 members including over 10,000 members who are Medicaid eligible. Our existing commercial and Medicare network is comprised of over 20,300 providers (primary care providers [PCPs] and specialists), and over 4,000 facilities (such as hospitals, ambulatory surgical centers, skilled nursing facilities, and radiology centers).

Where the targeted providers list is important and serves as the foundation of our network build, we have added additional providers to our target list based on what we have learned from community organizations such as Area Agencies on Aging and advocacy groups to identify where their members are currently receiving services.

Our network will include PCPs, specialist physicians, mental health providers, substance use disorder providers, hospitals, pharmacies, and other ancillary service providers. Section 6.2 describes the provider network requirements in more detail. Section 6.1 outlines in detail our approach to building the provider network in Iowa.

CARE COORDINATION EXPERIENCE

Committed to Health Care Transformation in Iowa

Skilled Case Managers play a significant role in the delivery of quality health care. Effective care management programs are a part of all of Aetna Medicaid's Medical Management programs and will be especially important to the success of benefit and service delivery. We will draw upon the experience of the health plans owned, administered, or supported by Aetna Medicaid, serving members who receive services comparable to services and benefits across the country. Our Case Managers have experience providing service coordination in various circumstances:

- **Collaborating with members and families to coordinate non-covered services to include out-of-network PCP or specialty services** – If a member needs services out of our network or specialty care, a Case Manager can convey the member's needs to our UM Department to obtain appropriate authorizations, as well as facilitate travel arrangements and housing for the member, if needed, during extended care away from home.
- **Facilitating member care through a health home and working in collaboration with the Health Home Care Coordinator** – If the health home has a service coordination program that has been determined to have the specific qualifications to meet the specific member needs, we may contract with the health home to provide the member's care coordination though a mutually beneficial rate structure and then monitor the care coordination process though the health home to make certain it is meeting member needs.
- **Developing transition planning for teens and young adults as they age into adult programs –** In facilitating transition planning for adulthood, we will emphasize education, workforce preparation, and independent living as we assist members with these important milestones. Our Transition Specialists will work in collaboration with each member's Case Manager to identify services members may need for a successful transition to adulthood.
- **Referring members to community agencies** – Members covered by Medicaid and dual-eligible members often benefit from assistance through community agencies. These can be a lifeline in providing services not traditionally covered by Medicaid or Medicare. These agencies can include disability resource centers, welfare departments and public assistance, religious organizations, family support agencies, advocacy groups, legal aid offices, Housing and Urban Development or other housing programs, or other types of community or support groups based on the individual needs of the member.
- **Planning for members who have been discharged from a facility** – The Case Manager will contact the member before discharge and will be involved in the discharge planning process. The Case Manager will contact the member shortly after discharge to be sure that all services are in place, prescriptions have been filled, and follow-up appointments are scheduled. The Case Manager will update the member's Individual Service Plan (ISP) and may schedule an Interdisciplinary Care Team

meeting. This team meeting will offer valuable insight in determining whether we should modify the member's ISP to meet the member's increased needs in the community.

Section 9 describes the service coordination requirements in more detail.

3.2.4 Integrated care

Attachment 5 – Section 3.2.4, Question 1 (SOW 3.2.4)

Describe proposed strategies to integrate the delivery of care across the healthcare delivery system.

Pioneer in Fully Integrated Care

Aetna Better Health will build on a track record of performance with Aetna Medicaid members, with acknowledged expertise and success in providing care coordination and care management services. We have been ***delivering integrated care since 1985 as an innovative Medicaid managed care*** plan in Arizona. We bring more than three decades of acknowledged performance with Medicaid members, with special expertise and success in providing care coordination and care management services. We improve performance and health outcomes through an integrated delivery system that is cost-effective and focused on evidence-based, high-quality health care services.

Our **Integrated Care Management (ICM) program** uses a disciplined methodology to identify our most biopsychosocially complex members—the ones for whom we can make the most difference. We involve these members in care management to remove or reduce barriers that limit their ability to manage their own health and well-being; to educate our members about chronic disease self-management; and to help them remain in the least restrictive and most integrated environment based on their own preferences, needs, safety, burden of illness, and availability of family or other supports and in a manner that is consistent with their personal and cultural values and beliefs. Our goal is to help them to develop resiliency and move toward recovery, reaching their self-defined level of optimal functioning.

As the first step, Aetna Better Health identifies members with a high medical risk by using our ***proprietary, evidence-based Consolidated Outreach and Risk Evaluation (CORE) application to analyze claims data.*** The scores are generated from Medicaid-specific, proprietary algorithms that we have developed internally based on data from our Medicaid populations as well as clinical and informatics expertise. The information fed into the algorithms includes demographics, medical claims, and pharmacy claims data.

The resulting inpatient and ED models provide member-specific scores indicating the likelihood that the member will visit the ED or experience an inpatient admission in the next 12 months. We run the model for our entire population monthly and the appropriate team reviews the results to identify opportunities for member contact and intervention.

Our model places members within one or more of three risk groups: high-risk for an ED visit; medium- or high-risk for an inpatient admission; or high-risk for high costs and poor outcomes in the next 12 months. We assess members for ICM based on the combination of risk groups to which they belong; each member receives a recommended stratification level, which we use to inform the ICM service level for which the member will later be assigned.

We are known for ***facilitating access to and coordinating the physical, behavioral, substance use disorder, and social support care for high-risk populations*** across many types of providers and organizations. Collaboration with members and caregivers, providers, community organizations, and state agencies is the key to our success. With this in mind, we have implemented a member-centered care management program to meet Agency care management requirements and holistically integrate

prevention, wellness, disease management, and specialized programs to coordinate care across an episode or continuum of care.

For many of our members, care management and disease management are what make their health care really work. Our success in complex cases often boils down to good old-fashioned care management. What sets our Case Managers apart is:

1. A focus on forming person-centered with members, providers and caregivers, and external agencies for collaboration and communication
2. The sophistication of our systems and tools

Case Managers take a "whole-person" view of their members. They understand how conditions and circumstances beyond the immediate complaint play into the reason the member is seeking treatment. The "whole-person" view helps them see beneath the condition to the reasons why the member might have trouble managing their health and having negative outcomes. This empathy and trust are what gets members to involve themselves more in their care and, as a result, have better health outcomes.

Collaboration with the community – Our members have relationships with the communities in which they live. We will support and build on these existing relationships and resources. Our care management services will connect members to our own clinical services and providers to enable seamless services.

Proven tools – We use enhanced technology and tools to better serve our members and providers, improve health outcomes, increase efficiency, and lower costs. We specifically configured our care management business application system to support our ICM program. This creates a true team approach between the member, provider, and Case Manager.

Our provider portal will allow will allow us to coordinate bi-directional communication between PCP, behavioral health specialists, and home and community-based services.

3.2.5 Emergency services

Attachment 5 – Section 3.2.5, Question 1(SOW 3.2.5.5)

Describe your strategies to reduce inappropriate use of the emergency room and to address members who frequently utilize emergency services.

Our approach to reducing utilization of the ED for non-emergent care centers combines identifying who the members are through predictive modeling and other data feeds, member and provider education, and provider incentives.

PREDICTIVE MODELING AND DATA FEEDS TO EVALUATE FOR FREQUENT ED USERS

Aetna Better Health will use our proprietary evidence-based CORE application to evaluate members with a high medical risk, such as high-risk for an ED visit. The resulting inpatient and ED models provide member-specific scores indicating the likelihood that the member will visit the ED or experience an inpatient admission in the next 12 months.

Our model places members within one or more of three risk groups: high-risk for an ED visit; high-risk for an inpatient admission; medium risk for an inpatient admission. Members are then assessed for ICM. By combining the information from the CORE tool with other member information, we contact members for enrollment into the ICM program at the most appropriate level of case management.

The model is run for our entire population monthly and reviewed by the appropriate team for member contact and intervention opportunities.

MEMBER INTERACTION AND EDUCATION

One group of emergency use high utilizers is members with behavioral health and substance use disorders. In many situations, Case Managers connect frequent ED users with other services that meet their needs. Motivational interviewing is a powerful tool for our Case Managers. Through effective questioning and listening, the Case Manager can look beyond symptoms, discover what truly motivates the member, and facilitate behavior change. Providers can also use motivational interviewing to engage members in reducing overall ED usage.

The Case Manager will also educate the member on the appropriate use of the ED, hospital, and PCP. We provide a 24/7 nurse line and a separate behavioral health line for members to contact.

PROVIDER EDUCATION

Provider Services Representatives will use regularly scheduled visits to provider sites as an opportunity for educational touch points, we will supplement these routine provider office visits with ad hoc provider office visits, emails, webinars, and statewide provider educational forums.

PATIENT CENTERED MEDICAL HOME

Aetna Better Health is committed to developing and expanding innovative payment and incentive models to improve quality, reduce costs, transform care delivery, and move beyond the traditional fee-for-service model. We base our approach on comprehensive value-based purchasing (VBP) programs of highly collaborative relationships with the provider community to maximize their participation with our programs to:

- Pay-for-Performance (P4P), which rewards providers if they demonstrate core competencies to provide quality care, enhance access and improve health outcomes
- Pay-for-Quality (P4Q), which rewards providers for achieving better performance on a broad spectrum of HEDIS and utilization metrics for their member panel

Through these value-based solutions, providers will have an incentive to refer the member to non-ED services in non-emergent situations.

INCREASE ACCESS TO AFTER-HOURS CARE, PROVIDE SAME-DAY APPOINTMENTS

Aetna Better Health will facilitate relevant data sharing capabilities to optimize provider awareness of their patients who may be overutilizing the ED because they are unable to secure appointments at their offices so that they and we can target interventions to these members.

We will incentivize providers to extend their hours and provide after-hours care.

We will also work with PCPs to offer same-day appointments for members with ambulatory-sensitive conditions who may otherwise use the ED.

In Kentucky we put together a workgroup to review ED utilization. We implemented a performance improvement project to reduce non-urgent and avoidable ED utilization that resulted in an 8.44% decrease in ED visits per 1,000 member months

POLICY FOR EMERGENCY SERVICES

If the member is admitted for the treatment of an emergency medical condition, members may receive emergency medical services both in and out of our network without first

obtaining prior authorization. We will not withhold payment for such services from providers, regardless of network status. However, we encourage the provider to notify us, which helps us coordinate care and participate in discharge planning. The Prior Authorizations Department will document the notification and PCP referral.

We will cover emergency and post-stabilization services rendered by qualified participating or out-of-network providers after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Attachment 5 – Section 3.2.5, Question 2 (SOW 3.2.5, 3.2.5.4)

Describe your plans to ensure a response within one (1) hour to all emergency room providers twenty four (24)-hours-a-day, seven (7)-days-a-week

For emergent care and behavioral health crisis, Aetna Better Health members can access care from any network or non-network provider or hospital 24/7. To assist members in the assessment of medical urgency or emergency, we will use the Aetna nurse advice hotline, which provides both medical and behavioral health triage. These nurse advice lines are a valuable resource to our members because they assess the clinical situation and help the member choose the most appropriate level of care using physician-directed protocols. We encourage providers to use their best judgment when referring patients to the ED. Our on-call professional staff will respond to emergent and safety needs at an ED or an urgent care center.

Quality and Value through Simple, Relevant Solutions

We will develop a network of urgent care and convenience clinics across Iowa that treat urgent conditions. We require all physical health and behavioral health providers to be available to provide direct care for our members 24/7 to treat emergency medical conditions.

Aetna Better Health provides coverage and is financially responsible for post-stabilization care services obtained in- or out-of-network without prior authorization based on this requirement. We also will cover emergency services without the need for a prior authorization for both in-network and out-of network providers.

Attachment 5 – Section 3.2.5, Question 3

Describe your plans to track emergency services notification of a member's presentation for emergency services.

Currently we learn about ED visits through notification of subsequent admission to inpatient or observation status or receipt of a claim. We will accept notification by telephone or fax. These notifications are maintained in our CORE business application system for processing and reporting functions.

We are in discussions with the Iowa Health Information Network (IHIN), and exploring options to accept real-time notifications of member emergency services through the IHIN for more timely intervention.

Attachment 5 – Section 3.2.5, Question 4 (SOW 3.2.5.1, 3.2.5.2)

Describe your plans for reimbursement of emergency services, including what processes will be implemented to determine if an emergency condition exists.

Our toll-free nurse advice lines are available 24/7 to help members assess the appropriate level of care (urgent, non-urgent, or emergent) using physician-directed protocols.

Aetna Better Health does not limit what constitutes an emergency medical condition based on lists of diagnoses, codes, or symptoms. We provide ED services that meet the prudent layperson guidelines as outlined above in RFP question 3.2.5.1.

Attachment 5 – Section 3.2.5, Question 5

Describe your plans to document a member's PCP referral to the emergency room and pay claims accordingly.

MEMBER REFERRAL TO THE EMERGENCY DEPARTMENT BY THE PCP

The PCP will obtain a prior authorization for the member to use the ED. This authorization will be submitted on the ED claim. We can individually identify providers who do not meet standards for these sources and conduct follow-up for education and improvement purposes.

PAYMENT OF PCP EMERGENCY DEPARTMENT REFERRAL CLAIMS

We will configure our claims processing system to automatically process these claims according to standard edits including authorizations. We will manually process claims that need review due to problem edits that did not pass the automatic claim adjudication process.

3.2.6 Pharmacy services

Attachment 5 – Section 3.2.6, Question 1 (SOW 3.2.6.1, 3.2.6.2.2.1, 3.2.6.2.2.2, 3.2.6.6.1, 3.2.6.6.2.1, 3.2.6.6.2.2, 3.2.6.6.2.3, 3.2.6.7, 3.2.6.7.1, 3.2.6.7.2, 3.2.6.8, 3.2.6.9, 3.2.6.11.1, 3.2.6.11.2)

Describe your proposed approach for delivering pharmacy benefits, including the use of any subcontractors.

Aetna Better Health will oversee the design and management of the pharmacy program as well as the Pharmacy Benefits Manager (PBM) activities of CVS Health. The management of the pharmacy benefit is an organization-wide endeavor, involving staff from Aetna Medicaid Pharmacy Management, along with the Aetna Better Health Quality Management, Provider Services, and Member Services Departments, as well as internal committees such as the Pharmacy and Therapeutics Committee. Our Head of Pharmacy for Iowa will be licensed in the state of Iowa and will be a collaborative member of the Integrated Case Management Team.

Aetna Better Health and Aetna Medicaid Pharmacy Management will be responsible for delegation oversight of the CVS Health contract. Figure 3-2 shows the division of responsibilities between Aetna Better Health, Aetna Medicaid, and CVS Health. We provide the clinical function of pharmacy management. This division provides the benefit of local oversight and management as well as data and reporting controls.

Our Member Services team is the gateway for members to access pharmacy benefit information and identify any challenges that may arise in fulfilling a prescription. The member does not need to interact with the PBM; our Member Services team will provide support on behalf of the member along with Aetna Pharmacy Management.

Aetna Medicaid employs 47 pharmacists and 52 pharmacy technicians.

We provide a direct line to retail pharmacies to contact our PBM to work through any reject messaging and resolve the issue, facilitate communication to provider for prior authorization submission, and issuing of emergency overrides based on a requirement for medical necessity review. We have direct access to the PBM systems for real-time access to claims and prior authorization review status.

Through PBM contractual requirements and our collaborative relationship with CVS Health, Aetna Better Health has the flexibility to request customization of PBM policies and procedures to meet the specific needs of the members. Aetna Medicaid and our PBM have worked together to successfully customize processes, policies, and procedures as necessary to meet all contractual requirements for each of our Medicaid customers.

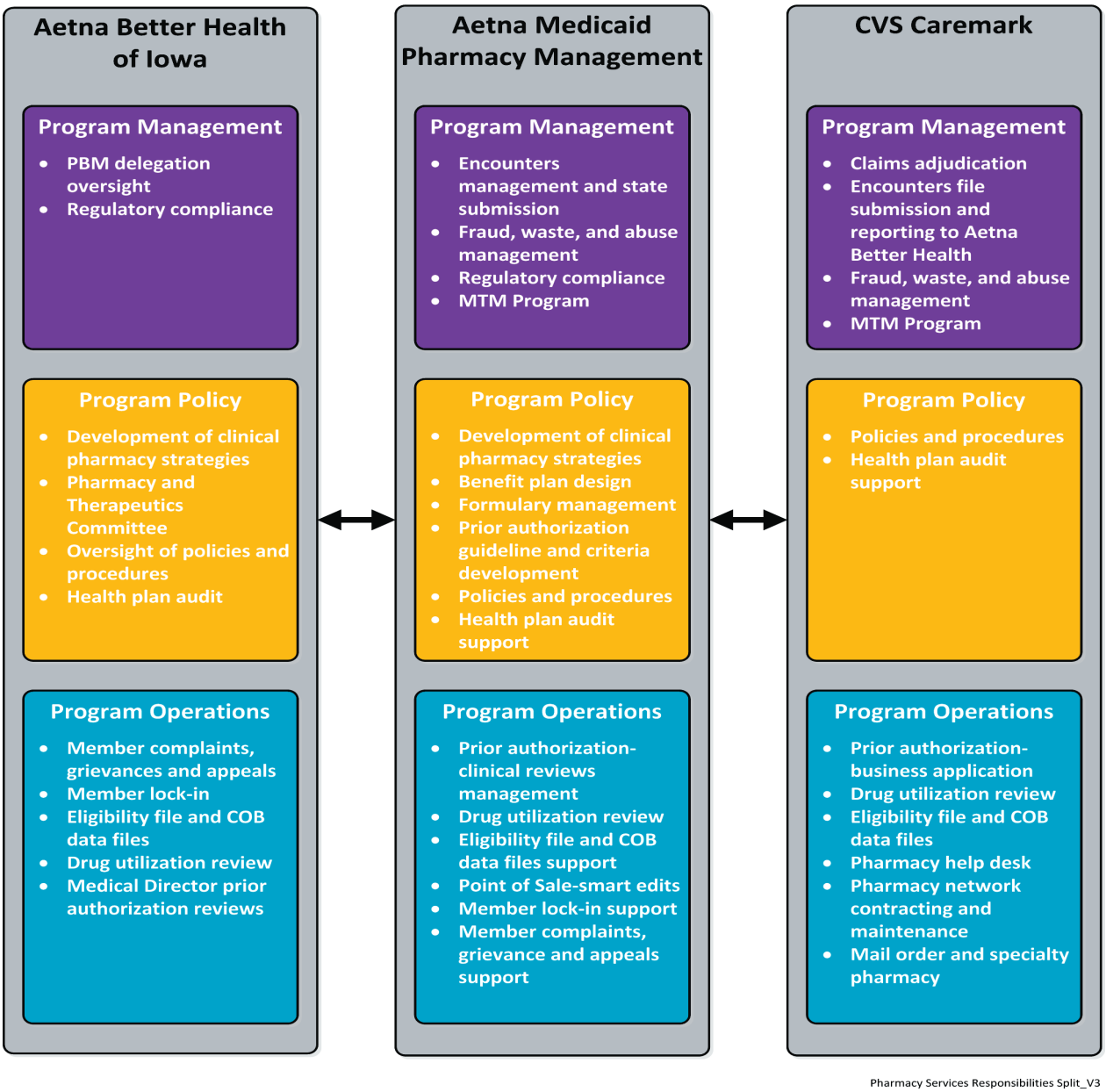
Examples of policies and procedures that we can customize include:

- Benefits configuration
- Claims processing requirements
- Encounter data reporting
- Procedures used to manage utilization (including prior authorization and utilization and clinical edits)
- Monthly prescription drug quantity limits
- Pharmacy prior authorization procedures
- Pharmacy Health Desk operations
- Pharmacy network access and availability to meet geography access requirements
- Performance Reporting
- Provider communications
- Member communications

We collaborate with our PBM to update front adjudication/ formulary edits to allow for seamless processing of prescriptions based on diagnosis, provider specialty, past drug utilization/claim history. This allows for seamless processing and management of the pharmacy benefits available to members.

The flexibility of our processes and systems provides a strong foundation for successful implementation of PBM services in Iowa and for achieving a smooth and timely rollout of new policies and processes to support the common pharmacy administrative framework that we will develop.

Figure 3-2: Division of pharmacy services responsibilities



Before pharmacy services begin, Aetna Better Health will submit to the Agency a written description of the assurances and procedures that CVS Health will have in place under our subcontract and of Aetna's right to oversee and audit such procedures. These will include provider issues, procedures, and safeguards for preventing patient steering, guarding the confidentiality of proprietary information, and avoiding conflicts of interest.

An important report used in managing pharmacy services and providing PBM oversight is the PBM's comprehensive Quarterly Costs and Trends Detail Report, which provides the following data:

- Claims statistics
- Claim reject metrics
- Top five rejected meds
- Claims prompt pay
- Value of generics
- Key comparisons

- Trend breakdown
- Specialty key statistics
- Channel management
- Top 10 indications
- Top 10 drugs
- Top specialty class
- Top specialty drugs
- Impact of patent expirations
- Generic fill comparison
- Prospective Drug Utilization Review (DUR) report
- Prior authorization activity
- Prior authorization call metrics
- Pharmacy Help Desk call metrics

Aetna Better Health will require our PBM to meet all reporting requirements for its functional responsibilities within the timeframes specified.

PREFERRED DRUG LIST

Aetna Better Health will develop the Iowa formulary in accordance with Section 3.2.6 Pharmacy Services and implement the Medicaid fee-for-service pharmacy benefit to include the Preferred Drug list (PDL), Recommended Drug List (RDL), and over-the-counter drugs. In addition, we will continually monitor and make recommendations to the State for changes to the formulary, including:

- FDA-approved generic drugs whenever available (generic substitution policy) as permitted by Iowa regulations and the PDL/RDL
- Exclude non-covered drugs, such as those defined by the Drug Efficacy Study and Implementation Program (DESI drugs)
- Prior authorization for specified injectables, frequently misused or abused agents, drugs subject to clinical edits, and all other drugs specified by the Agency
- Apply Pharmacy UM tools such as age restrictions, specialist requirements, quantity level limits, step therapies, and the Agency's clinical edits
- Formulary and PDL to align with daily changes to the formulary benefits files received from the Agency as well as any off-cycle updates

The Chief Medical Officer (or a designated Medical Director) and the Iowa-based Pharmacy Director are responsible for overseeing and enforcing the management of the formulary.

PHARMACY NETWORK AND ACCESS

Local Based Plan

Aetna Better Health has been at the forefront of providing quality provider care to our members. We can provide this care because of the collaborations we have built and maintained with our providers. Our partnership with CVS Health and their strong network of contract pharmacies are centered on providing access and choice for members. The network is composed of ***national and regional chains such as CVS retail pharmacies, Walgreens, Hy-Vee, and local independent pharmacies*** to best suit the needs of the smaller towns and communities.

Our members have access to a pharmacy directory link on the member portal. The information in the directory is updated weekly to provide up-to-date information.

PHARMACY ENCOUNTERS CLAIM SUBMISSION

We use an Encounter Data Management (EDM) system to warehouse and format encounter data to Agency requirements. This system will also warehouse encounter data from contractors and format it for submission to the Agency. We use this system to monitor data for accuracy, timeliness, and completeness of data prior to submission to the Agency.

The EDM system processes 837 professional and institutional encounters, including pharmacy and the most current coding protocols. EDM accurately and consistently tracks encounters throughout the

submission continuum of collection, validation, reporting, and correction. EDM accepts HIPAA-compliant 837 (I and/or P) encounter claims and National Council for Prescription Drug Programs (NCPDP) D.0 transactions.

We collect encounter claims information from multiple sources, including the claims adjudication system and third-party contractors under contract, such as pharmacy. The EDM system, the central repository for the collection of encounter claims, allows us to conduct a coordinated set of edits and data checks and to identify potential data issues at the earliest possible stage of the process.

Attachment 5 – Section 3.2.6, Question 2 (SOW 3.2.6.10)

Describe your ability and experience in obtaining and reporting drug rebates.

We will follow State requirements in regards to obtaining rebates regarding drug utilization. We will work with our contracted PBM, in providing any information to the Agency-related drug rebates.

CVS Health is renowned for its sophisticated, accurate, and reliable capabilities in both standard and ad hoc rebate reporting. They have the ability to provide a Rebate Summary report to Aetna Better Health on a quarterly basis and include the following Aetna Better Health-specific information:

- Total rebate dollars collected
- CVS Health's share of rebates
- Net rebates to client
- Client's total rebates paid to date
- Total rebates earned from each manufacturer (client-specific)

Additionally, CVS Health can provide Aetna Better Health with access to their user-friendly online reporting tool to access rebate reports. Some additional rebate reports include the following:

- **RPS Rebate Distribution Summary by Client Recovery Audit Contractor Report** – Provides a list of manufacturer invoice summaries, collections to date, prior allocations, and current allocations all broken out by quarter
- **Rebate Distribution Report by Hierarchy Quarterly** – Provides a breakdown of rebates by carrier, account, group, and quarter

Attachment 5 – Section 3.2.6, Question 3 (SOW 3.2.6.12.1)

Describe any relevant experience resolving drug rebate disputes with a manufacturer.

Aetna Better Health will be able to assist the State in resolving manufacturer rebate disputes. We will work in concert with our PBM vendor to research claims and then work with the pharmacy network to verify and validate the claims as needed. We also can use upfront adjudication edits to prevent the issues with can lead to rebate disputes.

CVS Health has an aggressive collection and reconciliation process related to rebate payments. All payments are fully reconciled to the original invoiced amount, and any differences are documented and escalated appropriately to provide that payment is made on all valid claims submitted to the drug manufacturers. Typically, agreements between the manufacturers and the PBM include language that provides arbitration to resolve a payment dispute with the contracted manufacturer.

Attachment 5 – Section 3.2.6, Question 4 (SOW 3.2.6.3, 3.2.6.3.1, 3.2.6.3.2, 3.2.6.3.3, 3.2.6.3.3.1, 3.2.6.3.3.2, 3.2.6.3.3.3, 3.2.6.3.3.4, 3.2.6.3.3.5, 3.2.6.3.3.6, 3.2.6.3.3.7, 3.2.6.3.3.8, 3.2.6.3.3.9, 3.2.6.3.3.10, 3.2.6.3.3.3.11, 3.2.6.3.4, 3.2.6.3.4.1, 3.2.6.3.4.2, 3.2.6.3.4.3, 3.2.6.3.4.4, 3.2.6.3.4.4.1, 3.2.6.3.4.4.2, 3.2.6.3.4.4.3, 3.2.6.3.4.4.5, 3.2.6.3.4.4.6)

Describe your plans for responding to all drug prior authorization requests within twenty-four (24) hours and dispensing at least a seventy-two (72) hour supply in an emergency situation.

TIMELY RESPONSE TO DRUG PRIOR AUTHORIZATION REQUESTS

Aetna Better Health recognizes that there are exceptions to standard guidelines to meet the needs of our member's with health care problems requiring medication therapy. Our prior authorization policy and the request process for prescribers provide that mechanism for consideration in a timely, cost-effective manner. To define the coverage exceptions process available to members for pharmaceuticals, prescribers may request a prior authorization to our automated coverage determinations through our prior authorization process.

Aetna Better Health providers can submit a pharmacy prior authorization by phone or fax. Prior authorization requests will be processed within 24 calendar hours of receipt from the prescribing provider.

Prescribing providers will complete education through the health plan website and provider manual on how to submit requests to the Aetna Better Health Pharmacy Prior Authorization unit for authorization review.

The prescribing provider's office must submit a pharmacy prior authorization request that includes all medical information and supporting documentation necessary to review the request. We will require the following information by telephone or fax to process the request:

- Member's name, date of birth, and identification number
- Prescribing provider's name, telephone, and fax numbers
- Medication name, dosage, and strength
- Diagnosis for which the medication is prescribed
- Other medications tried for the same indication
- Medical records to support the necessity for the authorization (for example, non-PDL drug, age limit, quantity limit, step therapy override, generic override, vacation override)

If the provider does not provide the requested information, the clinical pharmacist may contact the provider to request additional supporting medical documentation as part of the review process.

To support pharmacy authorization reviews, we will apply the State approved guidelines and the benefit design based on each individual member needs. We may authorize the filling of a prescription if any of the following conditions are met for drugs that we identify as non-PDL or that fall outside normal prescribing rules:

- Drug is deemed to be medically necessary
- Two PDL drugs (when available) in the same therapeutic category were used for an adequate trial and have not been effective
- PDL drugs in the same therapeutic category are contraindicated
- There is no therapeutic alternative listed on the PDL

72-HOUR EMERGENCY SUPPLY DISPENSING POLICY

To enable our members to receive required medications without delay, it is our standard procedure to authorize an emergency 72-hour supply until the request is reviewed. To request prior authorization, a provider must complete the pharmacy request form available through the Aetna Better Health provider manual and website. The provider will then submit the pharmacy prior authorization request directly to our PBM fax.

PROVIDER INFORMATION PORTAL

A set of online tools is available for a physician that provides efficient electronic prior authorization (ePA) and e-prescribing support. CVS Health has a web-based application that enables providers to input and manage ePA requests compliant HIPAA standards.

A prescription is submitted electronically by the physician. As the first ePA solution integrated directly into the e-prescribing workflow, the physician is electronically provided a list of alternative drugs that could be used without triggering a prior authorization. If the physician changes the prescription to one of these drugs, then the medication is approved and dispensed.

However, if the physician proceeds with the original prescription, then he or she can request the prior authorization question-set, submit answers, and receive a real-time response electronically. Sometimes, such as with select specialty drugs, the criteria set may require open-ended questions. As these situations require a higher level of clinical evaluation, the system redirects these requests to the manual review queue, where one of our qualified clinicians will review and make a determination. ePA helps improve physician satisfaction and get the medications to members faster.

Key application functionality and benefits to Iowa providers include:

- Real-time interface with our PBM's claims processing system
- All inbound faxes stored as digital image
- Single screen for entering prior authorization overrides
- Auto-scoring functionality for prior authorization approvals and denials
- Customizable denial letters to meet differing client needs
- Notification to members and physician before the prior authorization expires
- Audit trail of processed prior authorization requests
- Standard reports
- Dynamic workflow queues to allow clients to better manage prior authorizations
- Customizing system for client-specific holidays, weekends, time zones, business days, and calendar days
- Physician ePA for real-time submission and approval based on client criteria
- Providing access to full member claims history
- Enhancing drug search capability

Attachment 5 – Section 3.2.6, Question 5 (SOW 3.2.6.6.1.1, 3.2.6.6.1.5.1, 3.2.6.6.1.5.2, 3.2.6.6.1.5.3)

Describe your method for providing online and real-time rules-based point-of-sale claims processing for pharmacy benefits.

The skills of registered pharmacists, combined with CVS Health's technologically advanced online adjudication system, make for the most efficient point-of-service pharmacy benefit. CVS Health's standard online DUR, plan design, and safety edits complement and enhance the clinical expertise of our

registered pharmacists. Equipped with these tools, they can dispense drugs more cost-effectively and with greater safety—helping to fulfill the commitment of Right Medicine, Right Behavior to help improve member outcomes and reduce total health care costs.

Because all CVS Health retail network pharmacies are online, they can transmit claims electronically for verification of plan design and DUR. The online claims adjudication system is available 24/7, 365 days a year. In addition, network pharmacies can transmit claims through any of the switching companies (for example, RelayHealth [formerly known as Per-Se or NDC Health]), Emdeon (formerly known as WebMD or Envoy), or QS1 or by maintaining a direct link to our data center.

MEMBER IDENTIFICATION

When visiting a participating retail pharmacy, a member simply presents a prescription to the network pharmacist along with a member ID card. Since eligibility is verified online, the member ID card serves only as a convenient reference to the member's plan information for the pharmacist.

RECORDING OF PRESCRIPTION DATA

The pharmacist inputs the following information prior to transmitting the claim to CVS Health for adjudication

- Plan ID
- Days' supply
- Member number
- NDC number
- Relationship code
- Compound
- Gender
- Ingredient cost
- Date of birth
- Total price
- Date of service
- Prescriber ID
- Rx number
- Dispense-as-written code
- New/refill number
- Usual and customary
- Metric decimal quantity

DATA TRANSMISSION

The pharmacist transmits network claims to our system based on member eligibility, drug coverage, drug interactions, and co-pay/coinsurance specifications—all according to plan parameters. Using an established electronic data transfer network and available 24/7, the system is designed specifically to handle prescription drug claims.

CLAIMS ADJUDICATION

Our system applies each claim against the client's plan parameters for a specific member. When the claim is processed, the system applies up to 500 edits within seconds to verify:

- The claim is from a participating pharmacy.
- The member is eligible.
- The drug meets plan parameters.
- The appropriate quantity and days' supply of the medication were dispensed.
- The claim is priced accurately.
- The claim has not been duplicated or previously paid.

To help establish complete safety before the medication is dispensed, the system alerts the pharmacist immediately to the results of the DUR edits. In addition, it transmits the member's co-pay/coinsurance amount to the pharmacy within seconds.

PRESCRIPTION DISPENSING

Following adjudication, the pharmacist receives a message confirming that the claim has been approved or rejected. If the claim has been approved, the pharmacist's terminal designates it as payable; the price

and co-pay appear on the pharmacist's terminal as determined by the system. Once the claim has been adjudicated, the member submits the applicable co-pay and receives the medication along with a receipt indicating the prescription number, the date, and the amount paid.

REJECTED OR DENIED CLAIMS

A claim that has not been submitted properly by the pharmacy or encounters a system edit is rejected. Each claim that is rejected returns a reject code with the reason for rejection. In some scenarios, an additional electronic message is returned to the pharmacy to provide more information. Depending on the reject scenario, the pharmacy corrects the claim and resubmits it to CVS Health for processing.

Attachment 5 – Section 3.2.6, Question 6 (SOW 3.2.6.4, 3.2.6.4.1, 3.2.6.4.1.1, 3.2.6.4.2, 3.2.6.4.3, 3.2.6.4.4, 3.2.6.4.5, 3.2.6.5, 3.2.6.5.1, 3.2.6.5.2, 3.2.5.6.2.1, 3.2.6.5.2.2, 3.2.6.5.2.3)

Describe your plans to implement retrospective drug use review to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists and individuals receiving benefits, or associated with specific drugs or groups of drugs.

RETROSPECTIVE DRUG UTILIZATION REVIEW

Aetna Better Health has an extensive Pharmacy UM and DUR program to analyze member and provider drug utilization patterns and to develop applicable interventions or educational activities to strength the integration of pharmacy and care management activities. The program will also monitor the quality and appropriateness of care to our members. Our Pharmacy UM program includes:

- Member drug utilization
- Pharmacy dispensing patterns
- Practitioner prescribing patterns
- Drug prior authorization criteria
- PBM oversight activities in maintaining a Prospective DUR (Pro-DUR) process for identifying selected safety issues at the time of dispensing

Using pharmacy claims data, Aetna Better Health's Medical Director and Pharmacy Director will monitor daily, weekly, monthly, and quarterly management reports, including:

- Dollars and prescriptions (PMPM)
- Dollars (per prescription)
- Generic drug, single-source brand drug, and multi-source brand drug usage (percentages of total usage)
- Top 10 therapeutic category drug usage (by dollars and number of prescriptions)
- Top 20 drugs used (by dollars and number of prescriptions)

Based on these reports and trending analysis, we will implement interventions further to improve quality as well as control costs. These interventions may include:

- Provider education (targeted reminders, physician-to-physician discussions, intensified review of selected physicians)
- A requirement for step therapy related to specific medications
- Referring members to ICM
- Referrals to the Aetna Better Health Special Investigation Unit (SIU)
- Member lock-in evaluation

We evaluate our member and provider or program interventions and use these to make program changes to achieve desired outcomes. We will work with our PBM and ICM team to offer clinical solutions to improve member health and quality of care as well as evaluating opportunities that will reduce total costs.

By combining technology and extensive clinical resources, we will direct our PBM to intervene with members and physicians to help improve safety, reduce inappropriate drug utilization, and promote adherence to evidence-based care.

Aetna Better Health has an established DUR program that complies with federal law. Our Pharmacy Management DUR program consists of two components: Prospective Drug Review (Pro-DUR) and Retrospective Drug Review (RDUR). Our standards will be consistent with the standards established by the state of Iowa and we will submit our standards, as well as our policies and procedures, to the Agency for review and approval.

Under the direction of Aetna Better Health, our PBM will be responsible for conducting Pro-DUR activities that evaluate each drug therapy at the Point of Service (POS), before the prescription is filled, for potential drug therapy problems or fraud and abuse. We will conduct ongoing RDUR activities that assess or measure drug use based on a historical review of drug use data against explicit and predetermined criteria and standards.

Our PBM administers a Pro-DUR program that is consistent with the NCPDP Pro-DUR standard format. This Pro-DUR program evaluates each drug therapy at the pharmacy POS, before the prescription is filled, for potential drug therapy problems. Pro-DUR enables us to achieve better health outcomes, quality care, and reduced costs by preventing inappropriate drug use.

Our PBM operates an online, clinically based real-time, Electronic POS Claims Management System to identify important member-specific pharmaceutical care concerns through using POS system edits. The POS system edits are based on the latest information contained in official compendia and peer review literature. Online edits identify important drug-specific and member-specific safety concerns at the POS and encourage appropriate medication use.

Upon identifying a concern during a POS transaction, our PBM will immediately alert the network pharmacist who may then do one of the following:

1. Coordinate the member's complete drug therapy
2. Offer the member counseling regarding appropriate drug use
3. Consult with the prescriber about the appropriateness of the medication.

RETROSPECTIVE DUR

Aetna Better Health has written policies and procedures, tools, and outreach programs to assist in the detection of patterns of member prescription utilization. These patterns include prescribing, dispensing, or administering drugs that indicate possible therapeutic, clinical concerns, or potential fraud regarding certain types of medications (such as addictive substances and hypnotics).

Pharmacy claims data – We perform systematic analysis of pharmacy claims data (after claims adjudication) by using software that applies therapeutic and utilization criteria (for example, drug interaction, drug-disease interaction, drug-pregnancy interactions, addictive substances, long-term hypnotics, duplicate therapy). This will enable quick identification of medication conflicts or inappropriate utilization that merit intervention (for example, sending the prescriber a notification of

the concern identified through claims analysis, referring the member to ICM or the member Lock-in program, or conducting an onsite pharmacy audit).

Member utilization – We will periodically monitor members enrolled in our ICM programs for medication regimen adherence and appropriateness. Our ICM team will have access to member utilization data by types of drugs and volume. Once our ICM team identifies an issue, such as a member not refilling a chronic maintenance medication on schedule, they will:

1. Work with the member, the providers, and other involved individuals to develop and implement effective coordination and intervention strategies
2. Monitor and evaluate the effectiveness of these interventions on an ongoing basis

EDUCATION

We will conduct a monthly, in-depth analysis of types of drugs, volume, and cost. Our Medical Director and Pharmacy Director will review these provider profiles and exception reports to identify opportunities for improvement in the management of the pharmacy program. Based on this trend analysis, we may implement individual and/or program-wide interventions to improve coordination and quality (for example, provider education, changes to Pharmacy Management Processes).

Provider profiling reports are available through our online ad hoc reporting tool. These reports support a variety of clinical and cost-containment initiatives by creating reports using prescriber utilization data that focuses on the top 20 most prescribed drugs, generic utilization, and formulary adherence by a physician. Our PBM will provide us with the ability to share the reports with top prescribing physicians to compare performance to his/her peers. The reporting includes:

- Physician prescribing trends
- List of each physician's top 20 prescribed drugs by total costs
- Individual data and comparative information with peers in the same specialty or health plan
- Percentage of generics used when an appropriate generic exists
- Percentage of products prescribed in the formulary

By showing physicians how their prescribing patterns compare to their peers, we encourage them to adopt appropriate prescribing practices that will improve care for members and be cost-effective.

Aetna Better Health will educate both members and providers through a variety of communication strategies to promote appropriate utilization of the established PDL, including:

- Member handbook
- Aetna Better Health website
- Member newsletters
- Direct mail
- Members Services contact
- Care Management
- Aetna Better Health mobile app

Through these communication strategies, our goal is to educate our members on how to review the PDL and use the pharmacy benefit to support healthy outcomes.

LOCK-IN PROGRAM

Aetna Better Health will implement a Lock-in program. This program will limit the controlled substances that a member can receive from multiple pharmacies and providers when the member's utilization has met pre-established criteria.

We will adapt the protocols developed by Aetna Medicaid for monitoring and identifying the over-utilization and unnecessary or

inappropriate use of drugs to implement a member Pharmacy Lock-in program. The Aetna Better Health Quality Management/UM Committee and the Quality Management Oversight Committee (QMOC) will approve our Pharmacy Lock-in program criteria and specifications. We will submit our Pharmacy Lock-in Program policies, procedures, and criteria to the Agency for review and approval prior to implementation.

Our policies and procedures will follow all Iowa regulatory requirements and will incorporate at least the following criteria for member inclusion to the Lock-in program:

- Are getting early refills of narcotic medications or other controlled substances
- Are receiving medications from different prescribers within 90 days (more than 10 narcotic prescribers in 90 days)
- Are known to consistently overuse or misuse medications
- Have had three or more ED visits within 90 days for pain
- Have had hospital admission for overdose-poisoning within the past three months
- Violated a pain contract or Care Management agreement related to pain issues
- Have records indicating multiple PCP changes in the past year
- Have been implicated in third-party reports that indicate the member pays cash to get narcotics

We will monitor and identify inappropriate utilization (overuse, unnecessary use, or inappropriate use) of pharmacy benefits by reviewing quarterly pharmacy utilization reports. Case Managers and network providers may also make referrals for the Lock-in program when they identify members who are potential candidates for the program.

When we identify a member's pharmacy utilization as unusual, our Medical Director or delegated physician, Director of Pharmacy, and a representative from Care Management will review the member's medical records (pharmacy claims, hospitalization claims, and physician claims). We will notify the member in writing if we decide to lock-in the member.

Our Lock-in program typically involves locking the member into one provider or provider group to obtain prescriptions for controlled substances. While we encourage the member to select the lock-in provider, we will honor prescriptions from all network providers for other drugs and require that only controlled substance prescriptions and not all prescriptions be written by the lock-in physician.

During the 12-month lock-in period, we will provide the member with Care Management services and reinforce the messages about appropriate medication and pharmacy usage through member education. We will develop a plan for an education program for members and submit it to the Agency for review and approval. Before the anniversary of the restriction, we will review all utilization records to see that the member no longer requires the Lock-in program. Upon successful completion, we will notify the member of his or her disenrollment from the Lock-in program.

The member may appeal the lock-in decision within 30 days to our Grievance and Appeal Manager. If the member appeals, we place the lock-in on hold until the appeal period passes or the appeal is completed. Any member selected for lock-in will also have the right to fair-hearing procedures as offered under applicable Iowa law and federal regulations. The lock-in will not occur until after the time for appeal has expired or the appeal is resolved.

We will educate providers about our Lock-in program during provider orientation, in the provider manual, and on our website.

MEDICATION THERAPY MANAGEMENT

Poorly managed chronic conditions can result in high utilization of emergency and acute care facilities as well as increase the rates of inpatient hospitalization. Medication is a cost-effective way to manage many chronic conditions, but Medicaid members often face challenges that affect their ability to adhere to prescribed therapies. For example, they may have complex drug regimens due to multiple chronic conditions including mental illness. Members may have poor health literacy that makes it difficult for them to understand why, how, and when their prescriptions should be taken.

With oversight from our Iowa-based Pharmacy Director, our PBM will provide its ***Pharmacy Advisor® Support program to help to improve care for members with chronic conditions while helping to reduce total health care costs*** by promoting adherence and closing gaps in care.

Pharmacy Advisor® Support targets 12 prevalent and costly conditions, including depression, diabetes, high cholesterol, hypertension, and respiratory diseases. Through this program, the PBM will proactively communicate with physicians when members stop using prescribed therapies so that physicians can contact those members, encouraging them to keep taking their medications and explaining why it is important to do so. Improved adherence with medication regimens can help slow disease progression and reduce medical costs.

Through retrospective claims review, we will also use Pharmacy Advisor® Support to identify gaps in medication therapy, turning the prescription benefits plan into a powerful early-warning system for member care. The PBM will identify and address future opportunities for improved care before members experience severe health-related events. The program targets chronic conditions, including heart disease, diabetes, osteoporosis, and rheumatoid arthritis.

The PBM will identify members who may need additional medication or are taking an inappropriate or ineffective therapy. Within 72 hours of claims adjudication, we assess drug profiles for potential issues or complications. We communicate in writing the identified opportunities, clinical recommendations, and associated clinical references to the physician.

All of our PBM's Pharmacy Advisor® therapy intervention opportunities are developed by clinical pharmacists based on evidence-based clinical guidelines derived from the latest FDA-approved product labeling, national clinical guidelines, and published peer-reviewed clinical literature. We regularly review our interventions to be sure they are aligned with the most recent evidence-based prescribing practices.

We also apply proprietary software systems to identify potential high-risk members by analyzing integrated drug data using disease-specific clinical algorithms. Our PBM's clinical pharmacists may review complex, high-risk member profiles in detail; monitor for over-utilization or under-utilization (optimizing medication therapy); and contact the physician if necessary. The result is lower overall health care spending and higher quality of care.

Attachment 5 – Section 3.2.6, Question 7

Describe your plan for monitoring your PBM as described in Sections 3.2.6.6.1.3 and 3.2.6.6.1.4.

Aetna Better Health will submit to the Agency a written description of the assurances and procedures that CVS Health will have in place under our subcontract and of Aetna's right to oversee and audit such procedures. These will include provider issues, procedures and/or safeguards for preventing patient steering, guarding the confidentiality of proprietary information, and avoiding conflicts of interest.

An important report used in managing pharmacy services and providing PBM oversight is the PBM's comprehensive Quarterly Costs and Trends Detail Report, which provides the following data:

- Claims statistics
- Claim reject metrics
- Top five rejected meds
- Claims prompt pay
- Value of generics
- Key comparisons
- Trend breakdown
- Specialty key statistics
- Channel management
- Top 10 indications
- Top 10 drugs
- Top specialty class
- Top specialty drugs
- Impact of patent expirations
- Generic fill comparison
- Prospective DUR Report
- Prior authorization activity
- Prior authorization call metrics
- Pharmacy Help Desk call metrics

Aetna Better Health will require our PBM to meet all reporting requirements for its functional responsibilities within the timeframes specified.

3.2.7 EPSDT services

Attachment 5 – Section 3.2.7, Question 1 (SOW 3.2.7, 3.2.7.1)

Describe your plans to ensure the completion of health screens and preventive visits in accordance with the Care for Kids periodicity schedule.

CARE FOR KIDS/EPSDT

Aetna Better Health will provide EPSDT services under the Iowa Care for Kids program that focus on the required health care services that will be available and accessible to eligible members. Services will cover preventive; diagnostic; and treatment services (including physical, behavioral, dental, hearing, and vision screenings) as well as other treatment services that the provider deems medically necessary.

We will assist and encourage members, parents, or guardians of children to ***use resources effectively to improve health outcomes and better manage chronic conditions***. Our EPSDT plan will emphasize the core components of our efforts, including outreach, informing, screening, tracking, reporting, and compliance for children and adolescents.

Three Decades of Caring for Those Most Vulnerable

Aetna Medicaid successfully conducts EPSDT programs for children from birth to 21 years of age, as federally mandated, in all our plans. We have worked with state agencies, providers, and other stakeholders to administer the EPSDT plans and provide services that follow state and federal requirements.

We use NCQA HEDIS outcomes to track the results in improved care. For HEDIS 2014, our health plans demonstrated exceptional performance. Figure 3-3 shows the measures at the NCQA 90th and 75th percentile or higher.

Figure 3-3: [redacted] **– CONFIDENTIAL**

[redacted]

Aetna Better Health educates members about the importance of EPSDT screening***.*** We ***contact new members within 30 days of enrollment to offer assistance in accessing Care for Kids well-child visit services following the periodicity schedule.*** We also provide scheduling assistance and transportation assistance or mileage reimbursement for those members who are eligible for the benefit.

PCPS RECEIVE LISTS OF MEMBERS DUE FOR A CARE FOR KIDS VISIT

Each month, our Care for Kids Coordinator will send each of our PCPs a list of members due for a Care for Kids visit. This list will include members who lack Care for Kids checkups or immunizations. We will encourage PCPs to contact these members to schedule an appointment.

To further support compliance with the Care for Kids periodicity schedule, the Care for Kids Coordinator will post a flag in the member's record to alert providers regarding needs for Care for Kids checkups during queries regarding member eligibility.

IDENTIFYING CARE FOR KIDS MEMBERS WITH MISSED APPOINTMENTS

The Aetna Better Health Care for Kids Coordinator will receive a standard monthly Care for Kids intervention report to assist in identifying and contacting members who have missed Care for Kids required appointments. These intervention reports, besides containing member contact information, will also include the name and contact information for the member's PCP.

Should the Care for Kids Coordinator be unable to reach the member, we will contact the PCP to update the medical record. The PCP will address missing Care for Kids screenings when the member appears for his or her next appointment.

MONITORING AND IMPROVING ADHERENCE WITH PERIODICITY SCHEDULE

We use claims and encounter data to track adherence of Care for Kids services. For members, ***we send birthday reminders and missed appointment mailings to members***, their families, and guardians of members to remind them of necessary age-specific services, including well-care visits and immunizations. We also send monthly mailings to providers who have panel members overdue for a Care for Kids visit.

We will monitor Care for Kids metrics to identify trends and opportunities for improvement. Any child who has not received a well-care visit in the last 12 months will be a priority for follow-up. We require our network PCPs to provide all Care for Kids services in compliance with federal and state regulations and periodicity schedules. ***We will calculate provider-level HEDIS rates for the previous 12-month period to identify which members have gaps in care.*** These data will be used to support provider incentive strategies to increase participation rates.

Our system uses flags to alert staff when a member misses a Care for Kids service. These flags enable the staff member to discuss the overdue service with the parent or guardian in addition to the original reason for the call. This enhancement has improved collaboration and efficiency between the departments and decreased outbound calls to the members, their families, and guardians resulting in improved compliance with Care for Kids requirements.

IMPROVING MEMBER ADHERENCE WITH PERIODICITY SCHEDULE

Our Care for Kids Coordinator will work with members and providers to coordinate care to make certain that members get ***the right service, at the right time and at the right place***. If the service identified on the EPSDT screen will be not available through a contracted provider, we will execute a single-case agreement with the appropriate provider to meet the member's needs.

Local Based Plan

It is not always possible to complete all components of the full medical Care for Kids screening services during a single visit with a provider. Segments of the full Care for Kids may be completed by different providers. If a provider identifies a problem during a well-child visit, the provider can treat the problem at that time or refer the parent and child member to providers, programs, or agencies that are qualified to treat the condition.

Should a specialized service be unavailable in the member's community, we will arrange transportation and coordinate other services as necessary to facilitate the member receiving the required care.

If the PCP determines that the child is in need of services that cannot be provided by a network provider (for example, transplant), our Care for Kids Coordinator will work with the out-of-network provider to get a single-case agreement to provide the medically necessary services for the child.

For children with special health care needs, our Care for Kids Coordinator will work with the assigned Case Manager as well as family members, caregivers, and community-based organizations to further ***assist members in accessing needed services.***

Committed to Health Care Transformation in Iowa

When a PCP refers a Care for Kids eligible member to a carved-out service, the Care for Kids Coordinator will assist the member in making contact with the contractor and in coordinating care - avoiding unnecessary duplication of services and providing timely access to all medically necessary services.

Attachment 5 – Section 3.2.7, Question 2 (SOW 3.2.7.2, 3.2.7.3)

Describe your proposed outreach, monitoring and evaluation strategies for EPSDT.

OUTREACH—QUALITY CORE: RISK-STRATIFIED QUALITY MEASURE INTERVENTION LIST

Aetna Medicaid has developed Quality CORE, a tool that applies risk stratification to health plan member outreach lists, targeting those members who are non-adherent for specific quality measures.

Focused initially on HEDIS quality measures, Aetna has applied a collection of predictive models—created specifically for each quality measure—that assesses the member's risk for being non-adherent for a particular measure. These predictive models represent this risk as a probability between 0 to 100%, where the higher the score, the more likely the member is to be non-adherent for a given measure.

These scores will allow us to stratify the population by non-adherence risk and engage them through appropriate outreach. The predictive model applies a ***three-tiered approach, focusing on key indicators***:

- Demographics (age, gender, race/ethnicity)
- Past adherence history (member past history of adherence to a measure)
- Special measure-specific indicators (for example, measures specific to chronic disease)

Table 3-1 summarizes data types, sources, and key features.

Table 3-1: Quality CORE System components, sources and key features

Component	Sources	Key features (not all-inclusive)
Quality Measure Rate Report	• HEDIS data from Quality Measurement system • HEDIS performance targets • NCQA Medicaid percentiles	• Plan's year to date (YTD) summary of overall member's adherence rate for HEDIS measures tied to EPSDT • Number of members in the EPSDT-related measures that are compliant as compared to those with gaps in care • Monthly YTD HEDIS rates and comparisons to up to three years of prior history, performance target, projected rate
Member Adherence & Gap-in-Care lists/reports	• QNXT™ claims/encounters • Care & UM data • Pharmacy data • HEDIS data	• Member demographics, ethnicity • Prior history of compliance • Member's PCP, providers seen most often • Inpatient/ED utilization, last date of service, current gaps in care • Predicted adherence (high, medium, low) • Member outreach notes/attempts
Provider and Provider Group – member Gap-in-Care lists/reports	• QNXT™ claims/encounters • Pharmacy data • Provider contracts • Care & UM data • HEDIS data	• Percentage of members by provider group • Members assigned and their gap-in-care list • Member pharmacy, inpatient, and ED utilization trends • Member's past adherence • Member's known conditions and CORE score

We will apply the Quality CORE to develop outreach lists for Care for Kids related HEDIS measures in Iowa. Outreach lists will contain the member contact information, as well as the member's current assigned PCP (and their contact information). The lists will also provide a full view of any additional measures that a given member may or may not be adherent to and any other indicators that may provide a better view of action steps to help support care. ***These quality measure reports will support analysis of adherence rates over time, tracking rates month over month and comparing rates to the prior year.***

CARE FOR KIDS PROMOTION AND EDUCATION

We combine health promotion and education activities and materials to improve the understanding of the Care for Kids program by members and their families and caregivers. Our outreach activities and materials help members and their families and caregivers understand the value of this critical program, provide information on how to access Care for Kids services, and assist members in using these services. Outreach activities in Missouri ***increased adolescent immunizations by 8% and childhood immunizations by 4% in our EPSDT program in one year.***

Adolescents are more likely than other groups to participate in activities that-risk their overall health. Three out of four adolescents aged 12 to 19 years report engaging in at least one of the following risky behaviors:

- Use and abuse of alcohol and other substances
- Unprotected sex
- Poor eating and exercise habits
- Physically endangering behaviors

Our Care for Kids outreach and education strategies includes:

- **General education and information** – The materials we develop and employ to support Care for Kids adherence include the member handbook, member newsletters, surveys, on-hold messaging, health-related brochures, and website content. Our member handbook includes information on the Care for Kids program, child health guidelines, and tips to keep children and youth healthy. Our member newsletters include articles about the value of the Care for Kids program.
- **Adolescent Member Advisory Council** – We will establish an Adolescent Member Advisory Council dedicated to adolescent members and their caregivers to better understand the root causes of missed well-care visits for this age group. We will collaborate with our teen members to design, develop, and implement this program so that incentives will be appropriate and effective for them.
- **Mobile Application**– We will use our mobile application to send personalized text or phone messages for appoint reminders, search the provider directory, message their care team.
- **Adolescent screening physical** – We will provide a member incentive program to encourage routine screenings for adolescents to seek regular preventive care and services. We will offer a gift card for the completion of these services. Refer to Section 3.2.14 for details of this service.
- **Adolescent screening physical** – We will provide a member incentive program to encourage routine screenings for adolescents to seek regular preventive care and services. We will offer a gift card for the completion of these services. Refer to Section 3.2.14 for details of this service.
- **Automated voice messaging** – We use an automated voice messaging system to remind members of upcoming well-child checkups and to follow up on missed appointments. We also use our Member Services toll-free line to educate callers during their brief on-hold waiting periods about various aspects of the Care for Kids program, and include Care for Kids reminders on our website. All content presented in these various formats are included on our website for easy reference.
- **Population-specific information** – Our Outreach Coordinators send a variety of age-specific health materials to inform our members and their families and caregivers about our Care for Kids program. We mail an age-specific postcard to the homes of members who are due for a well-child visit.
- **Community collaboration** – We collaborate with community-based organizations and public agencies with similar goals. We share EPSDT information as well as information about our PCP network education at health fairs, group gatherings, and other community events. Our Quality Improvement and Community Development teams and representatives from local community organizations work together to identify specific topics to address.

Our Ted E. Bear, M.D.℠ program will engage young members and their families and increase use of preventive health care services. All children enrolled in the health plan are automatically members of the Ted E. Bear, M.D. club and will receive benefits.

We will offer Ted E. Bear, M.D. visits for community gatherings, schools, 4-H clubs, and YMCA

locations to teach healthy habits.

Through a partnership with the Boy Scouts of America and Girl Scouts of Iowa, we will pay for the cost of an annual Scout membership for all Kids Club members. As a bonus, Kids Club members who join Boy Scouts get the Boys' Life magazine each year they are a Scout. Kids Club members who join Girl Scouts will receive credit toward Scout materials. Girls may choose one of two options after six months of continued participation: A Girl's Guide to Girl Scouting (including one Journey Book) or a basic uniform.

We will also offer memberships to the Boys and Girls Clubs in Iowa. The mission of the Boys and Girls Club is "to enable all young people, especially those who need us most, to reach their full potential as productive, caring, responsible citizens."

EVALUATION—QUALITY MEASUREMENT SYSTEM: QUALITY SPECTRUM INSIGHT

Aetna Better Health intends to use Inovalon's Quality Spectrum Insight (QSI®), an NCQA-certified software tool for HEDIS and quality measurement. QSI offers enhanced tools to meet our regulatory submission requirements as well as support internal quality improvement initiatives. We will import data from our claims and supplemental data sources to into our quality measurement software to calculate annual and monthly performance measures. The system will include standard CMS 416 logic for the purposes of monitoring EPSDT indicators.

Tables 3-2 and 3-3 summarize data types, sources, and key features:

Table 3-2: EPSDT/QSI data files, data sources, and data components

Data file	Data sources	Data components (as available)
Member and provider-level detail	• State (834 file) • Provider contracts	• Address, telephone, and demographic information • Full member and provider-level detail results for each measure • Functionality for data review, rate review, comparison, and investigation tools
Historical data	• State (claims file)	• Member claims and diagnosis history
Claims data	• QNXT™ • Encounter data through ancillary providers	• Member ID, rendering provider ID, date of service, discharge status, payment status, diagnosis codes, units of service, place of service, DRG, HCPCS, CPT pharmacy codes, date of service, encounter data
Pharmacy utilization data	• CVS Health claim or encounters data	• Member identification, provider ID and name, prescriptions codes, standard HEDIS codes, dates of service, scrip filled date, quantity/units dispensed/paid, days' supply, refill indicator, denial reason code
Behavioral health utilization data	• Claims or encounter data • Specialty behavioral health provider data (if available)	• Member ID, rendering provider ID, date of service, units of service, place of service, Member ID, provider data from the Iowa behavioral health provider
Immunization utilization data	• State data	• State data report from database: Member ID, name, date of birth, date of service, procedure code
Laboratory data	• Claims and contracted lab contractor	• Member ID, name, date of birth, date of service, procedure code, diagnosis code, lab results

Table 3-3: EPSDT/QSI system components and key features

System components	Key features (not all-inclusive)
Data integration	• Advanced data integration tools that easily adapt to non-standard data layouts • Aggregate data from multiple sources
Processing data for production of quality measures	• Flexibility to create customized data runs for differing periods to offer insight into quality trends • Ability to create reporting on a monthly basis to review year-to-date progress as well as a rolling 12-month view in addition to annual reporting
Customization of software	• Ability to create customized quality measures that are not standard NCQA HEDIS measures such as the CMS 416 EPSDT measure • Ability to create ad hoc reporting for custom views into data tailored to plan needs
Reporting Capabilities	• Functionality for data review rate review, comparison, and investigation tools • Graphical tools allow clinical staff to craft their own measures without involving programmers • Robust data quality analysis support • Data validation reporting

MONITORING

Reports will also include a breakdown of adherence rates by providers and provider groups, as well as distribution of non-adherent members for a given measure. We will organize this distribution by adherence risk, showing what proportion of a provider's panel is at higher versus lower risk for non-adherence for a specific measure. This will ***assist the Care for Kids Coordinator in focusing outreach and contact with specific provider groups that may have a higher proportion of non-adherent members***.

We will report well-child visits through encounter data submissions per the requirements regarding encounter data and appropriate well-child codes established by the Agency. If data other than encounter data used, we will certify that data with the Agency.

We will use a series of coordinated systems and protocols to identify, track, account for, and validate Care for Kids/EPSDT data. Through these coordinated systems, we will meet Agency specifications and requirements for EPSDT reporting. We will produce annual and monthly clinical measurement, HEDIS rates, and reports. We will calculate annual HEDIS rates for submission to NCQA and state Medicaid agencies. We will develop monthly reports to monitor ongoing performance.

3.2.8 Behavioral health services

Attachment 5 – Section 3.2.8, Question 1 (SOW 3.2.8.2, 3.2.8.4)

Describe your proposed approach to delivering behavioral health services, including the use of any subcontractors.

Pioneer in Fully Integrated Care Our strategy is to provide the most cost-effective, high-quality, evidence-based treatment in the least restrictive setting that can safely meet the needs of the member. We support the member in becoming an active and informed decision-maker in his or her own care. Members are permitted to select any in-network provider without a referral.

We have been ***providing ICM since 1989*** including behavioral health, physical health, social, educational, and other community-based support services. Our approach incorporates the Iowa principles for care integration.

AETNA BETTER HEALTH'S WHOLE-PERSON APPROACH

Aetna Medicaid uses several strategies so people with behavioral health disorders receive optimal treatment. In doing so, we minimize reliance on ED visits, inpatient hospitalization, long-term residential treatment, and other long-term institutional placements. We support the use of ambulatory treatment settings along a continuum of care and home- and community-based wraparound services and supports.

By optimizing access to and availability of these alternative levels of care, we make it easier for people to get effective treatment earlier in the course of their illness. The natural outcome is a decrease in utilization of the more intensive, restrictive, and expensive services that can be disruptive, stigmatizing, and potentially traumatic to the individual.

Aetna Better Health supports the Agency's vision of improving access, quality, and efficiency of behavioral health services for Medicaid members. We will work to achieve these outcomes through a variety of evidence-based services that we will coordinate to meet specific member needs. Our outreach program helps members, their families, and their circles of support understand the benefits available through integrated health care. We will help members access appropriate behavioral health by:

- Developing, maintaining, and expanding a comprehensive, accessible behavioral health network including the support and expansion of Integrated Health Homes (IHHs)
- Keeping the provider network list up to date and available on the member portal
- Creating and distributing easy-to-understand member materials so that they know how to access services
- Promoting collaborative relationships between members and their PCPs so that PCPs can also assist members to seek appropriate behavioral health services
- Maintaining well-trained Member Services staff who can recognize when members may need behavioral health services and put them in touch with our Care Management staff or help them find providers for self-referral
- Hiring, training, and maintaining adequate clinicians trained in behavioral health
- When needed, working with members one on one to schedule and keep provider appointments

When our ICM team develops a Care Plan, ***we will specify all required services as a part of the plan, even though those services might not be covered directly by Aetna Better Health***. During the Care Plan development, our Case Managers explain to members the importance of sharing relevant medical and clinical information, working with the member to authorize appropriate information exchange. We also share the care plan with all of the member's care team they identify and give permission to have the care plan. In this way, we maintain our focus on integrated care for the member.

Providing member-centered care coordination services – Our care coordination is centered on the member, family members, and their circle of support.

Identifying and employing the most effective intensity of service, evidence-based treatment interventions, covered benefits, and community resources – The assessment and re-assessment process supports understanding of the level of care and services required for each member and also considers the dynamic changes occurring in each member's life. We facilitate access to a continuum of services, including those covered by Medicaid, as well as community resources that address each member's root causes of underlying gaps in care and supportive services.

In addition, our approach is to directly assist each member in accessing treatment based on the intensity and complexity of each member's needs consistent with the member's personal and cultural values, beliefs, and preferences. Member choice and direct involvement in decision making is paramount.

Engaging the member holistically – The Aetna Medicaid Case Manager is the single point of contact, engaging the member in a collaborative working relationship that continues throughout the ICM process as the member recovers, becomes increasingly resilient, and ultimately becomes better able to manage his or her own continuing recovery and health care. Together they develop a Care Plan that addresses the member's critical physical, behavioral, and social needs. The Case Manager is the coach, facilitator, and integrator for ICM and care coordination activities across the full continuum of services.

All of our Case Management staff are trained in and use motivational interviewing. Motivational interviewing ***"is a person-centered method of guiding to strengthen personal motivation for change."*** (Rollnick and Miller, 2009). Motivational interviewing uses engagement skills throughout every encounter with the member. It starts with the premise that members are competent have self-knowledge, attitudes, and capabilities to effect change. Engaging the member starts with understanding their personal story, values, and goals and continues along a spectrum connecting those values and goals to the behavioral change. Motivational interviewing also:

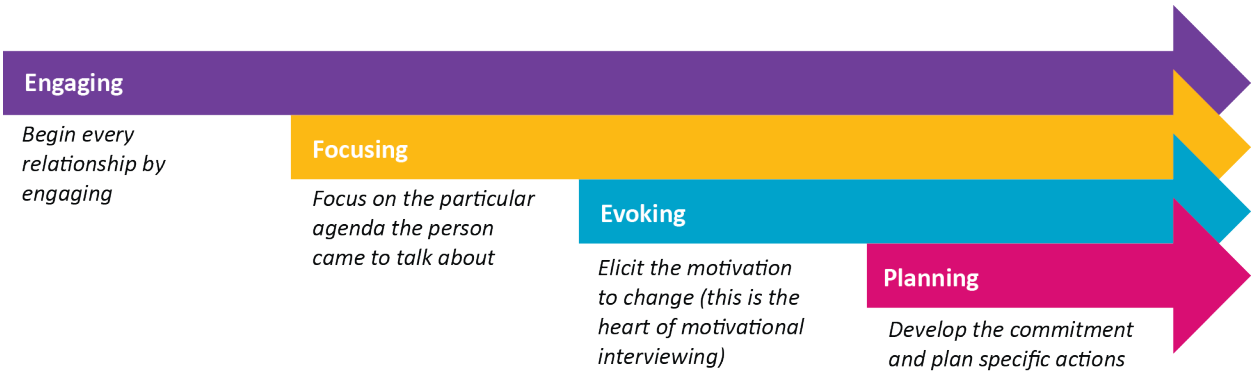
- Encompasses a person's desires, abilities, and cultural background
- Engages individual
- Increases internal motivation to consider change

In 2010 a company-wide initiative implemented motivational interviewing into the Disease Management Programs. Member engagement increased from 53.1% in 2009 to 76% in 2011 and dropouts decreased 55% during the same period.

During the motivational interviewing encounter, the clinician elicits change talk (member activation), works with the member to explore any ambivalence about change, and then connects the behavior change to the member's values and goals when creating a plan. This approach increases the member's internal motivation. This is particularly helpful in engaging members who have a history of inconsistent involvement in treatment.

The Motivational Interviewing Conceptual Model (Figure 3-4) illustrates how member engagement is part of every stage.

Figure 3-4: Motivational Interviewing Conceptual Model



Teaming with the member, family, representatives, and care providers to address all member needs – The Care Coordination Team addresses complex needs for members. This interdisciplinary team

combines core competencies in physical and behavioral health with the capacity to incorporate biopsychosocial wraparound services to address the most critical root causes limiting each person's health improvement. The team is led by the Case Manager and coordinates the delivery of services and supports for the member.

Use of certified Peer Support specialist – As part of the integrated team, Aetna Better Health will employ certified peer support staff to accomplish system transformation, such as:

- Participate in interdisciplinary rounds where they provide suggestions on how to best approach cases. Focus on cultural sensitivity and competency (person-first language, independent living philosophy, and other strength-based approaches).
- Assist in developing Member Newsletter articles, emails and other communication further exploring ways in which Care Managers can better advocate for members.
- Provide subject matter expertise to representatives of various departments.

"Michael" is a 15-year-old member who was adopted by his grandmother. He experienced childhood trauma due to emotional and physical neglect he endured while under the care of his biological mother who struggled with mental health and substance use disorder issues. Michael had extremely challenging behavior, including impulsivity and explosive outbursts both at school and at home. His grandmother was proactive in working with the local school district and mental health professionals in order to get Michael the help he needed. He was diagnosed with Asperger's syndrome.

Michael received an individualized education plan (IEP) so that he had the needed accommodations to allow him to excel academically. After multiple previous inpatient psychiatric hospitalizations, he was finally stabilized in a therapeutic group home.

Michael's grandmother, school staff (including his behavioral health counselor, psychologist, teachers, behavioral support staff), group home leaders, treating psychiatrist, and his long-term care health plan worked collaboratively with one another. The health plan provided direct staff who worked with Michael's treatment interventions to assist him in using effective coping skills to manage his anger and frustration and find appropriate ways to express himself. The school and group home were also proactive in teaching Michael basic life skills and foster independence. They implemented an intensive behavioral action plan that would be used both at school, group home, and when he had home passes.

In time, Michael himself became proactive in managing his treatment. He learned self-control, became assertive and appropriate in expressing his needs, wants, and goals. His school staff worked collaboratively with a vocational rehabilitation agency. During his senior year in high school, Michael began taking classes at a local community college. He wanted to become an auto mechanic. The vocational rehab agency helped Michael to apply and get accepted to a highly respected auto mechanic school. He even got a scholarship. He also got his driver's license.

Collaborating with providers and stakeholders to expand and support our Integrated System of Care model – We focus on coordinating and integrating fragmented services into an integrated system of care that addresses each member's individual needs within the context of that person's family and cultural community.

To achieve these outcomes, we will engage the community, especially providers, with a ***focus on providing appropriate services to these members at the right level of care.*** Our emphasis will be on increasing access to community-based ambulatory and wraparound services that will result in sustained recovery and resilience, improved quality of live, and moving people toward becoming productive members of society.

Integrated Health Homes – We will encourage adults with serious mental illness (SMI) and children with severe emotional disturbance (SED) to select an Integrated Health Home. In addition, we are planning to add substance use disorder (SUD) treatment and services to the Integrated Health Home model for our network.

We encourage access to treatment for SUDs. We continually work to expand access and availability to SUD treatment. We expand our panel of providers as we identify service or geographic gaps and new providers entering the market.

Our provider network will include independently practicing, facilities, and programs that can provide the full spectrum of behavioral health treatment.

Aetna Better Health's program will keep members aware of all available treatment solutions for their particular behavioral health concerns. We will provide numerous points of access and work with members to provide information and answer questions. Our website and the member handbook will offer behavioral health-specific materials that educate members and define services.

The ***goal of the basic behavioral health outreach program will be to inform members of covered services, how to access those services, and help promote optimal use of the services.*** Our member outreach will include:

- Informing members about their benefits and coverage, regardless of the program in which they are enrolled
- Offering information on when to seek treatment
- Giving tips on following a specific Care Plan
- Educating members on numerous common behavioral health disorders
- Explaining how to get the most out of behavioral health appointments
- Educating providers on how to engage members with behavioral health care needs
- Training members on the importance of both medication management and therapy
- Teaching members how to work best with providers
- Creating knowledgeable consumers of behavioral health services
- Pointing members toward community resources and services that offer additional support
- Providing outreach to special populations, including:
  - Members who speak a primary language other than English
  - High-risk members
  - Victims of abuse
  - Individuals with dual diagnoses

Aetna Better Health will offer a more targeted approach for members with more intensive needs. In addition to incorporating all aspects of basic outreach, we will offer specific information tailored to the situational needs of the member.

TELEHEALTH AND TELEMEDICINE: IMPROVING ACCESS TO BEHAVIORAL HEALTH SERVICES

Aetna Better Health is committed to expanding access to behavioral health services to remote areas as part our Integrated System of Care model using the telehealth/telemedicine model and technology.

Explore Ideas to Make the World a Better Place

Telehealth and Telemedicine services have been shown to improve much needed access, health outcomes, reduce disease burden in communities, and promote the concurrent use of advanced specialty capabilities in coordination with a member's local PCP, thereby improving the quality of care available from the PCP. Our telehealth program will promote provider-to-provider consultation between PCPs and specialists serving rural or underserved urban areas.

We will contract with existing behavioral telehealth providers in the state of Iowa as well as look to expand select services in the State with our contracted telemedicine vendor. Likewise, we will provide telemedicine services to provide access to behavioral health care for our members where appropriate.

This new technology will allow for virtual visits either in a member's home or while at the provider's office. We will initially pilot this model with select providers that have the capability to incorporate the technology and workflows into their office environment. We will look to rapidly expand where appropriate with a focus on improving access in rural and underserved urban communities.

HOW WE SUPPORT INTEGRATED (BEHAVIORAL) HEALTH HOME MODELS

Aetna Medicaid has developed a fully integrated system of care model, inspired by the CMS-approved Health Home model. In this integrated service delivery system, we identify and provide care management coordination of medical care, behavioral health care, pharmacy, community, and social support.

Our Arizona Medicaid plan is working to finalize the development of health homes for our members with SMI. Our Ohio Medicaid plan implemented the health homes over a year ago that features care coordination and services for adults with SMI and children with SED.

The goals of these health homes are to:

- Improve the integration of behavioral and physical health care
- Decrease avoidable hospital ED use
- Reduce hospital admissions and re-admissions
- Reduce health care costs
- Improve quality outcomes especially those tied to prevention and wellness
- Increase community tenure
- Improve the experience of care, quality of life, and consumer satisfaction with improved health outcomes
- Support members in receiving care with their usual and most trusted provider

Committed to Health Care Transformation in Iowa

Our ICM teams will consult on the development, implementation, and coordination of all health homes within their regions and help facilitate the person-centered coordination, communication, and collaboration necessary for members to demonstrate progress on the goals and actions of their Care Plans. Additionally, we are prepared to implement payment reform models such as P4Q with health homes based on their performance on the quality measures listed above.

Our goal is to improve the health, wellness, and quality of life for those impacted by behavioral health needs in Iowa, specifically for members receiving services through the Office of Behavioral Health.

Attachment 5 – Section 3.2.8, Question 2 (SOW 3.2.8.1)

Describe how your proposed approach will incorporate the values outlined in Section 3.2.8.1.

EMPHASIS ON RECOVERY AND RESILIENCY—KEY VALUES AND PRINCIPLES OF OUR BEHAVIORAL HEALTH PRACTICES AND POLICIES

Recovery and resiliency are foundational principles of our ICM program for all members, including those who have SMI/SPMI or SED. At the heart of a recovery-oriented system is the empirically supported belief that people with serious behavioral health issues can, and do, recover.

Aetna Better Health focuses on behavioral health services built on the foundational principles of recovery and resiliency. We will expect our behavioral health providers to incorporate these concepts into the member-centered ISPs and help members meet their short- and long-term health care goals. Behavioral health providers must have the training and experience to appropriately incorporate the following fundamental components into each member's ISP.

Focus on recovery with the goal that the member will have decreased acute symptoms and achieve his or her optimal level of functioning. The Case Manager ensures that the member has the right mix and intensity of services, regardless of whether we will be the primary payer for those services, and that the services are well-coordinated to avoid or eliminate duplication or gaps in service.

Focus on resiliency by enhancing the protective factors that will sustain members as their needs change over time. We consider adequate social supports for members and their circles of support, such as respite care. The Case Manager helps the member or representative plan for changing circumstances.

Sustain optimal level of functioning to make certain that the member is receiving the right mix and intensity of services and has moved to self-management of health care services. Members will be living in the most integrated and least restrictive setting that meets their preferences or those of their representatives. The Case Manager will re-assess each member when there appears to be a change to the member's level of functioning or symptomatology to determine if there have been any significant changes in the level of care and associated needs.

Table 3-4 outlines the fundamental components of our behavioral health services and the approach to incorporate these for the members we serve.

Table 3-4: Fundamental components

Fundamental component	Approach
Hope	Recovery provides the essential, motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized, but it can also be fostered by peers, families, friends, providers, and others. ***Hope is the catalyst of the recovery process***.
Self-direction	By definition, ***the recovery process must be self-directed by members*** who define their own life goals and design a unique path toward them.
Empowerment	***Members have the authority to choose from a range of options and participate in all decisions, including the allocation of resources that will affect their lives***; we educate and support members.

Fundamental component	Approach
Member strengths	Care planning and recovery focus on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of members. By building on these strengths, members can leave dysfunctional life roles and take on new life roles: partner, caregiver, friend, student, and staff. ***The process of recovery advances through interaction with others in supportive, trust-based relationships.***
Holistic perspective, (productive role)	***Care and recovery encompass a member's whole life, including mind, body, spirit, and community.*** Care planning incorporates all aspects of life, including housing, employment, education, mental and physical health services, complementary and naturalistic services, addiction services, spirituality, creativity, social networks, community participation, and family supports as determined by the member.
Individualization	***Care plans and ISPs are developed based on members' unique strengths and resiliencies*** and their needs, preferences, experiences, and cultural backgrounds in all of their diverse representations.
Respect, (eliminating stigma)	Community, systems, societal acceptance, and appreciating members for who they are, including protecting their rights and eliminating discrimination and stigma, are crucial to achieving recovery. ***Self-acceptance and regaining belief in one's self are particularly vital***.
Nonlinear approach	Recovery is not a linear process. It is based on continual growth, occasional setbacks, and learning from experience. ***Recovery begins with the awareness that positive change is possible***, that awareness enables the member to move on to fully participate in the care and recovery process.
Peer support	***Mutual support, including the sharing of experiential knowledge, skills, and social learning, plays an invaluable role in recovery.*** We encourage members to involve other individuals in recovery to provide each other with a sense of belonging, supportive relationships, valued roles, and community.
Responsibility	***Members have a personal responsibility for their own self-care and journeys of recovery***. Taking steps toward their goals often requires great courage. We encourage and empower members to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

Attachment 5 – Section 3.2.8, Question 3 (SOW 3.2.8.3)

Describe how your proposed approach will engage families, natural supports, advocacy organizations and network providers in the behavioral health care planning and care delivery process.

Listen, Respect, and Act with Insight, Understanding, Compassion

Aetna Better Health believes that people in recovery can provide vital support to each other in achieving long-term recovery and that these individuals can play important roles in designing, delivering, and evaluating services. We also believe in our members' ability to achieve and retain their resiliency through numerous strategies and innovations.

Motivational Interviewing is a powerful skill set in the toolbox of our Case Managers. Through effective questioning and listening, the Case Manager can look beyond symptoms, discover what truly motivates the member, and facilitate behavior change. We examine biopsychosocial domains to fully understand the member's condition and situation. We can also use motivational interviewing to make certain we are addressing the member's priorities and natural supports, such as family.

As we train Case Managers, we use the case study of a member named Sue. Sue is not taking her medications to prevent psychotic symptoms. In role-playing exercises, we have Case Managers ask Sue questions to learn more.

For example, if the Case Manager asks, "Sue, what is keeping you from taking the medication your doctor prescribed?" Sue may answer "I'm worried about my son; he doesn't have anywhere to go after school and sometimes he doesn't come right home." As the Case Managers ask other questions and listen, they will quickly find that Sue's values—specifically, her concern for her son—trump all other considerations, including her own health.

For Case Managers, the goal is to connect Sue's values to future positive behavior by first addressing her main concerns. In this case, the Case Manager would adapt her approach to focus on Sue's concerns about her son and suggest ways in which we can help, such as finding a community agency with an afterschool program or a reliable, trusted neighbor who can watch her son regularly.

By addressing Sue's personal priorities first, we can begin to examine deeper aspects of Sue's situation. For example, the Case Manager might say, "Sue, we've found a safe place for your son after school. It's obvious you're concerned and want to be a good parent to him. We know that it's hard to be there for him when you are hearing voices. If you take your medication, you'll be able to be more present for him. Is that something you are willing to try?"

The Case Manager might find that Sue is ready to change—or might find a whole new area that must be addressed before we can move on.

LIVING ROOM PROGRAM

We are currently evaluating the creation of a Living Room Program in Iowa. This program model has been successful in other states such as Illinois and Arizona. The Living Room is place where members can go when they feel they are in a state of crisis.

In the Arizona model, it is a center where adults in psychiatric crisis can go, instead of making an unnecessary trip to the ED. A person can go there and get "talked" down. The central location in Phoenix is a living room setting with couches and a TV, a refrigerator with snacks, and rest areas around the perimeter in small rooms. There are a couple of small office spaces where peers could meet privately with people and where they can do paperwork.

The staff includes licensed therapists and counselors and certified peers. It is an inexpensive, evidence based, and member friendly way to divert the crisis and avoid further trauma to the member. Additionally, in many of these facilities, members work with the peer staff to begin or edit Wellness Recovery Action Plans and use other evidence-based services while working to decrease the crisis.

MENTAL HEALTH FIRST AID

Aetna Behavioral Health is working with Mental Health First Aid USA to promote their education and training program for professionals and non-professionals. Similar to CPR and First Aid training, Mental Health First Aid is an 8-hour education program that helps participants identify, understand, and respond to signs of mental illnesses and SUDs.

We will provide Mental Health First Aid training to all member-facing Aetna Better Health staff in Iowa.

Mental Health First Aid is an evidence-based, international program. Peer-reviewed studies published in Australia, where the program originated, show that individuals trained in the program:

- Grow their knowledge of signs, symptoms, and risk factors of mental illnesses and addictions.
- Can identify multiple types of professional and self-help resources for individuals with a mental illness or addiction.
- Increase their confidence in and likelihood to help an individual in distress.
- Show increased mental wellness themselves.

Studies also show that the program reduces the social distance created by negative attitudes and perceptions of individuals with mental illnesses.

We have conducted adult and youth workshops over the past year. Table 3-5 shows our audience and attendance.

Table 3-5: Mental Health First Aid Workshop 2014/2015 attendance

Audience	Attendance
All Aetna employees	723
Medicaid employees	611
All contracted providers	45
Medicaid facing providers	45
All community members	177
Medicaid-facing community members	134
Total of all attendees	**943**

SUPPORTING MEDICAID TRANSFORMATION THROUGH A SHARED GOVERNANCE COMMITTEE STRUCTURE

We are evaluating creation of a committee as a central decision-making mechanism for the contract and the avenue through which we can systematically address concerns about the program, review changes, and make changes. The committee would directly support the transformation goals of the state of Iowa and Aetna Better Health and will include State representatives currently involved in planning the State's goals wherever possible.

The shared governance structure for the committee would include Aetna appointees and community stakeholders, including member and family representatives, providers, and a representative appointed by the regional Mental Health and Disability Services Redesign. We envision a total of 12 members: 6 Aetna appointees and 6 stakeholder representatives with staggered terms. The committee would make decisions through a majority voting process. In the event of a tie, committee members would continue to discuss the issue until they reach a majority vote. This voting structure forces issue resolution, generates a consensus-building process, promotes collaboration, and fosters accountability.

Through our partnership with the Agency, local community-based organizations, providers, and members, we will collaborate to establish the policies, best practices, quality strategies, reporting requirements, and communication protocols to meet the State's needs and to maintain consistent continuity of care for members.

Attachment 5 – Section 3.2.8, Question 4 (SOW 3.2.8.8)

Describe your proposed peer support/counseling program.

PEER SUPPORT SERVICES AS A LINK TO INTEGRATED SERVICES

As part of the expansion of peer support services, we believe that engaging peers to collaborate with PCPs in a navigation role will be extremely helpful to providers and members. Peers in this role will increase the rate by which members follow up with recommended referrals for specialized care. Research demonstrates that peers provide emotional, informational, and instrumental support as well as kinship crucial to recovery. We encourage an enhanced role for peers, as described below.

Many of our members are more likely to engage with peers with whom they can discuss shared experiences. The Warm Line program provides a meaningful enhancement to crisis services. Through the Warm Line, Certified Peer Specialists will take calls that are supportive in nature.

In the Aetna Better Health model of ICM, we work to coordinate all care for the member even for care that is not included in our benefit package and managed by us. This approach mirrors the peer-run whole health self-management model described by the SAMHSA-HRSA Center for Integrated Health Solutions. ***Whole Health Action Management (WHAM) is a training and peer support group model developed to encourage increased resiliency, wellness, and self-management of health and behavioral health*** among people with mental illness and SUDs.

WHAM enhances and expands the role of peer support services in health care delivery and also provides a support system for peers and for members as they work toward their individual health goals. Peers assist with navigation, linkage, and support, as well as coaching members in self-management and recovery techniques that may apply to physical or behavioral health issues, depending on the member's unique situation.

Committed to Health Care Transformation in Iowa

In this model of navigation for primary care, we envision peers assisting with referrals for diverse specialized services, including behavioral health care, tobacco cessation programs, weight management activities, and other services recommended by the member's PCP. Some peers will help address the self-management of diabetes, asthma, and other illnesses that are frequently comorbid with behavioral health disorders. ***Peers can work directly with the providers and behavioral health professionals*** and paraprofessionals who are ***assisting the practice to screen and refer members***.

According to the American Academy of Family Physicians Foundation, evidence demonstrates that peer support is a critical and effective strategy for ongoing health care and sustained behavioral change for people with chronic diseases and other conditions. Its benefits can extend across the community, organization, and society.

Peer interaction can help the member by supporting the feeling of purpose to conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society. It is not unusual for members to delay, or perhaps avoid entirely, recommended services that may be perceived as intimidating or that may carry a social stigma, such as mental health or SUD treatment. Peers can help mitigate these fears by providing support for an individual who has lived with some length of recovery.

Peers who provide the support also benefit. They report less depression, heightened self-esteem and self-efficacy, and improved quality of life.

Overall, studies have found that social support from peers:

- **Decreases morbidity and mortality rates**
- **Increases life expectancy**
- **Increases knowledge of a disease**
- **Improves self-efficacy**
- **Improves self-reported health status and self-care skills, including medication adherence**
- **Reduces use of emergency services**

LEADERS IN PROVIDING PEER AND FAMILY SUPPORT

As an example, our Arizona plan established a leadership role in creating opportunities for and confirming peer and family involvement at all levels of the system. This department is led and staffed by individuals with lived experience or who are family members of persons experiencing mental health challenges. The key activities of this department are:

- Building partnerships with individuals, families, youth, and key stakeholders to promote recovery, resiliency, and wellness
- Establishing structure and mechanisms to increase the member, family, and community in having a voice in areas of leadership, service delivery, and system administration
- Advocating for service environments that are supportive, welcoming, and recovery oriented by working with providers to implement trauma-informed care service delivery approaches
- Communicating and collaborating with members and families to identify concerns and remove barriers that affect service delivery and member satisfaction
- Promoting the development and use of member and family support programs
- Collaborating with State offices and stakeholders
- Facilitating and participating in internal and external trainings to educate staff, behavioral health providers, physical health providers, and community members on recovery-oriented systems of care
- Monitoring and evaluating system indicators of success and recovery and providing regular reports to leadership
- Chairing the Member Advocacy Committee, ensuring coverage and action on key issues
- Managing all staff in the Individual and Family Affairs Department, confirming adherence to company policies and procedures.

We intend to employ two new Recovery and Resiliency Admins to assist in these areas.

Attachment 5 – Section 3.2.8, Question 5 (SOW 3.2.8.10)

Describe your services for prevention and early intervention.

Our system of care will be accessible and comprehensive and will fully integrate an array of prevention and treatment services for all age groups that will be informed by evidence, responsive to changing needs, and built on a foundation of continuous quality improvement. Members will receive services that

are based on their personal preferences and identified as important for high standards of care: recovery, resiliency, improved outcomes, screening, and prevention.

Services ***include prevention programs for adults and children and a full continuum of services for adults with SUD and general mental health disorders***, adults with SMI, and children with SED. We work with providers and members to identify barriers that impact access to care and investigate other factors that impact preventive care service rates, such as misunderstandings on the part of the members.

During new provider orientation as well as during provider forums, we ask providers to engage our Member Services Representatives when members miss appointments. Additionally, upon assignment of a new member, providers receive a letter that asks the provider to notify us if a member has frequent no-shows. To facilitate this reporting, we supply a form that is available on our website that our providers use to tell us if a member has missed appointments. After we receive this form, our Member Services Representatives contact the members and explain the importance of keeping scheduled appointments or of rescheduling appointments.

After reviewing this process with providers in other states, Aetna Medicaid has experienced increased cooperation from providers in notifying us of members who miss preventive care appointments as evidenced by the increase in the number of forms we have received from providers.

CARE FOR KIDS/EPSDT

We facilitate Care for Kids/EPSDT well-child visits for eligible members under the age of 21 to identify health and developmental problems. We cover an EPSDT visit in addition to a sick visit, sports physical, or a visit for another purpose or procedure on the same day. EPSDT screening completion is also included as a P4Q provider quality measure, which is one factor that influences provider incentives.

See Section 3.2.7 for full details on our Care for Kids/EPSDT program.

COORDINATING MEMBER CRISIS STABILIZATION SERVICES

Members of priority populations, including those who may need specialized behavioral health services on a regular basis, may experience a crisis. ***We will provide access to our 24-hour crisis line to all of our members.*** Proactive crisis intervention and referral can help these members remain in community-based services and avoid unnecessary admissions to an inpatient setting.

Aetna Better Health will establish a network of providers of crisis services including 24 hour crisis response, mobile crisis, crisis assessment and evaluation, and observation services in a hospital. Prior authorization or referral will not be required.

The following, Table 3-6, outlines our key crisis stabilization processes and activities.

Table 3-6: Crisis stabilization services

Process	Activities
A comprehensive and integrated crisis system connected to the State's crisis access number	The system will offer: • Prompt access to crisis services to address member needs in the community whenever possible and appropriate • A comprehensive risk assessment • Trained crisis clinicians to resolve member situations on the phone, if possible, or assist in accessing the full continuum of crisis services, including mobile crisis services, urgent psychiatric care, community stabilization teams, crisis transportation, detox, and crisis and peer respite services

Process	Activities
24-Hour Nurse Line available to members 24 hours a day, seven days a week	The 24-Hour Nurse Line is accessible through our nationwide behavioral health crisis line and will offer: • Member education, information, and access to resources to address any medical concerns • Access to the integrated care and services they need to resolve their crisis • Access to crisis centers across the State • Telehealth in rural areas
Mobile crisis teams available to fill the gaps, especially in very rural areas	Development of crisis services from a regional perspective to address the needs of members who are competing for the attention of ED staff when they experience acute psychiatric or addiction disorder crises might seek hospital ED care. We will offer adult, youth, and child members in crisis situations prompt action, gentle response, and effective support in a respectful environment through the use of mobile crisis services. • Mobile crisis services can also find and serve members who reside in very rural areas and do not have access to adequate transportation to services. • Our mobile crisis services can go to member homes and more readily stabilize member situations and, hopefully, eliminate the need for travel to a hospital or psychiatric facility.
Immediate access to clinicians and referral assistance for a broad range of other community services	We will offer Aetna Better Health members a less costly and traumatizing alternative to hospitalization and other restrictive levels of care. • Available 24/7, the multi-disciplinary crisis stabilization team will provide rapid intervention for those who do not meet criteria for inpatient psychiatric care but are experiencing problems that could escalate to a point of requiring hospitalization • Crisis resolution and individualized structured therapeutic activities are provided to individuals within a social rehabilitation treatment model • Alternative services to help members maintain stability in their communities, including creative approaches to unique member situations, such as the need for dog-sitting to alleviate worry about a pet while attending medical appointments
Mobile crisis teams to meet the specific needs of the Aetna Better Health membership	For members who can safely remain in the community, our mobile crisis model will: • Engage members and natural supports to stabilize the immediate crisis situation • Be tailored to meet the needs of members within the context of their community, whether that is in an urban, suburban, or rural area • Identify and work with strengths and natural supports within member families and communities.
Create a crisis plan for guidance in case the situation re-escalates	A short-term crisis plan includes: • Methods for symptom management • Identification of available support systems on which the member can rely if symptoms begin to exacerbate • Contact information for the primary provider • Provision for the crisis team's coordination of services with the member's current behavioral health provider to address follow-up care

UTILIZATION MANAGEMENT

We will conduct UM through appropriately licensed and trained health care professionals using evidence-based guidelines approved by the Agency. Our UM program focuses on preventing waste, optimizing care, and identifying and addressing evidence of over- or under-utilization.

Attachment 5 – Section 3.2.8, Question 6 (SOW 3.2.8.15, 3.2.8.16)

Describe how you will ensure providers conduct outreach activities for IDPH participants who are IV drug users.

Aetna Better Health will have a network of providers who provide substance use treatment to Iowa Department of Public Health (IDPH) participants. As part of the contractual agreement, we will require

these providers to use trained outreach workers to call individuals with IV SUDs. We encourage the providers to use certified peer support specialists in this role. The outreach calls will be documented and reported to Aetna Better Health no less than quarterly.

We will conduct outreach training for providers related to IDPH participants who are IV drug users. Our website will offer a training webinar that providers can access at their convenience.

Our Case Managers will be available to answer questions from providers who serve IDPH participants.

Attachment 5 – Section 3.2.8, Question 7 (SOW 3.2.8.18)

Describe how you will support IDPH funded Women and Children services

We recognize the challenges to identify and engage pregnant women with SUD. Beyond identification and engagement, we will:

- Provide rapid access to SUD treatment if the member will agree
- Facilitate ready access to prenatal care with providers who understand the special care needed for these women during pregnancy and delivery
- Identify babies with neonatal abstinence syndrome while they are still in the hospital for optimal discharge planning and engagement of the parents or guardians in care management
- Follow the babies closely in the neonatal intensive care unit (NICU) for appropriate treatment and for bed leveling where this is permitted
- Follow these children carefully for at least the first year of life to make certain they are getting regular well-child care
- Avoid preventable re-admissions and ED visits

To meet this challenge, Aetna Better Health launched a pilot in April 2014 to engage pregnant women who have significant substance use or addiction in prenatal care management to facilitate care management with the same Case Manager for the mother and baby for the first year of the baby's life. In cases where the mother was not in care management, we engage both while the baby is in the hospital.

Since the program began, we have enrolled 263 members: 106 mothers, 157 babies. From April 1 to December 31, 2014, our initial finding is the average NICU utilization per thousand members decreased from 2.76 before program implementation to 1.65 post implementation. We have also achieved a cost savings of $110,468. Outcomes from this pilot program are being evaluated for use in Iowa.

Attachment 5 – Section 3.2.8, Question 8 (SOW 3.2.8.18)

Describe your screening and treatment protocol for children with serious behavioral health conditions. Provide a sample crisis plan and describe how you will work in collaboration with local school systems.

CHILDREN'S SCREENING AND TREATMENT BEHAVIORAL HEALTH PROTOCOLS

We use the PSC-17, a brief screening questionnaire that improves the recognition and treatment of psychosocial concerns in children. Based on results of this screening, we make certain the child is referred to the appropriate services. For example, if the child scores is likely to have Attention Deficit Hyperactivity Disorder (ADHD), we will refer the child to an ADHD specialist.

COLLABORATING WITH LOCAL SCHOOLS

Our innovative outreach and engagement processes support shared decision making, member choice, and the priorities and goals of the member as recorded in the member's care plan. For children who are still attending school, it is critical to involve educational personnel such as classroom staff and counselors who may be working with the child while they are in school. These children may have IEPs, which must be factored into any assessment or care planning process. To the extent possible, and with authorization from the member or their representative, the Care Plan will include school-based information and service plans created outside of our health plan, including IEPs, if available. Please see Appendix C for the Crisis Plan.

Attachment 5 – Section 3.2.8, Question 9 (SOW 3.2.8.20)

Describe how you will ensure compliance with the Mental Health Parity and Addiction Equity Act.

COMPLIANCE WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

We understand and will follow this requirement, which is The Wellstone-Domenici Mental Health Parity and Addiction Equality Act of 2008 and 45CFR Parts 146 and 147.

We currently adhere to the compliance indicators outlined for Medicaid managed care organizations (MCOs) in the State Health Official Letter that CMS released on January 16, 2013, regarding the application of the Mental Health Parity and Addiction Equity Act requirements to Medicaid MCOs, alternative benefit plans (ABPs), and the CHIP. Aetna Better Health adheres to the state Medicaid contract requirements for benefits plan financial limitations, quantitative treatment limitations, and non-quantitative limitations in the Medicaid state plan as specified in CMS-approved contracts. We are currently reviewing the CMS proposed regulations issued on April 10, 2015, implementing MHPAEA for Medicaid. We will comply with the requirements of the final regulations.

Attachment 5 – Section 3.2.8, Question 10 (SOW 3.2.8.9, 3.2.8.21)

Describe how you will provide care that addresses the physical and behavioral health needs of members in an integrated manner.

Our approach incorporates the Iowa principles for care integration while also identifying and promoting the safest, evidence-based, and most cost-effective treatment for members:

- Mental illness and addiction are health care issues and must be integrated into a comprehensive physical and behavioral health care system.
- Many people suffer from both mental illness and addiction. As members seek care, providers must understand, identify, and treat both illnesses as distinct conditions.
- Provide and promote care coordination tied to shared workflows, hand-offs, and care transitions where appropriate with our provider network.
- The system of care will be accessible and comprehensive and will fully integrate an array of prevention and treatment services for all age groups that will be informed by evidence, responsive to changing needs, and built on a foundation of continuous quality improvement.
- It is important that relevant clinical information is accessible to both the primary and behavioral health providers consistent with federal and State laws and other applicable standards of medical record confidentiality and the protection of patient privacy.

Our incorporation of these principles is represented by:

- **Member-centered ICM –** Our care coordination model focuses on the member, his or her family, and their circle of support.
- **Assisting members in accessing appropriate behavioral health care** – Our Health Home Model of ICM consistently maintains focus on whole-person health and supports the Agency's vision of improving access, quality, and efficiency of behavioral health services.
- **Treatment management expertise** – Our integrated and whole-person model of care pays full attention to the special biopsychosocial needs of those members with behavioral health conditions, whether the complex condition is primary or secondary. This means the application of the full suite of diagnostic and treatment options focuses on the right care at the right time.

Listen, Respect, and Act with Insight, Understanding, Compassion

To improve delivery and access to mental health outpatient services for high-risk members, in other states we have collaborated with several outpatient practices and therapists to provide mental health services in members' homes. Due to stigma or physical limitations, many members do not access care in community offices but do feel much more comfortable talking with a therapist in their home environment. With the member's consent, our Case Manager joins the therapist and the member at a session to confirm that any issues or approaches identified between the member and the therapist are incorporated in the member's Care Plan. Other community locations may also be viable options and do not carry the stigma of a behavioral health office, such as a school or mobile health care clinic.

ICM GUIDING PRINCIPLES

The foundation of our ICM approach includes the following guiding principles:

- **Moving from disease focus to member focus –** Evaluating every member for physical, behavioral, and social risks to their current and future health
- **Identifying and employing the most effective intensity of evidence-based, plan-covered systems and services –** Facilitating access to a continuum of services based on the intensity and complexity of each member's needs
- **Behavioral engagement for change –** Using a single point of contact to engage each member in a plan that addresses their critical physical, behavioral, and social needs to promote resiliency, recovery, and optimal self-management
- **Teaming with the member and care providers to enhance care outcomes –** Working as an interdisciplinary team that combines core competencies in physical and behavioral health within a systems framework to manage psychosocial complexity and challenging relationships with members and their families
- **Collaboration with plan sponsors to influence benefit design –** Focusing on coordinating and integrating fragmented services into a system of care that addresses each member's individual needs within the context of their family and cultural community

Aetna Better Health builds on member strengths to organize the Care Management team, encouraging and supporting the member to take increased responsibility for their health care. Our technique is to systematically monitor covered and medically necessary services for high-risk members with chronic or complex needs, while improving the member's health and quality of life and decreasing utilization and cost. This is accomplished within the context of ***four key components: autonomy, engagement, resiliency, and recovery.***

Attachment 5 – Section 3.2.8, Question 11 (SOW 3.2.8.21)

Describe your mechanisms for facilitating the reciprocal exchange of health information between physical and behavioral health providers and methods for evaluating the effectiveness of such strategies.

COLLABORATIVE CARE MODEL—COORDINATION OF SERVICES FOR MEMBERS NOT IN AN INTEGRATED HEALTH HOME

Aetna Better Health uses a collaborative approach that informs all our programs, regardless of the benefits we manage. In our model, we work to coordinate all biopsychosocial care for the member. We coordinate with the member's entire care team: PCPs; Case Managers; behavioral health providers; peer, family, and community supports; and HCBS providers. ***We work with the entire care team whether within the health home setting or in separate practices, to provide care, share information, and monitor and support the member progress.***

This approach has shown to be both clinically and cost-effective for a broad scope of behavioral health conditions, in numerous settings, and using a variety of payment mechanisms (Unutzer, et al, 2013). This model defines integrated care as a system in which providers from each domain work together to impact member care and health outcomes.

The goal for our collaborative care programming is to support providers in improving their ability to deliver quality, member-centered care that is fully integrated, easily accessible, comprehensive, cost-effective, well-coordinated, and minimizes duplication of services.

We will use our member and provider secure portals, reporting tools, and technology strategy to share information to share information. The portal tools can serve as the single source of truth where care management, claims management, and other information can be viewed by the entire care team.

We will collaborate with the Agency and IDPH and maintain and enhance relationships with providers, facilities, and community resources with experience in meeting the diverse and complex needs of members and work together with them to provide a quality, comprehensive care package.

Driving our approach is the collaborative care model. This model serves as our foundational building block to create a health care neighborhood where our members can easily access care from a full continuum of providers aligned in a coordinated system of care.

Initially, we will work with select providers to design and develop a fully integrated approach to health care. Where appropriate, we will implement a common, shared practice environment and the development of a common Care Plan using a biopsychosocial approach. Our Care Management and Quality teams will review trends in quality and cost outcomes. They will meet with providers to see that they have access to this information. We will consider behavioral health, physical health, and social factors in every step of our process.

Members will receive services based on their personal preferences and identified as important for high standards of care: recovery, resiliency, improved outcomes, screening, and prevention.

3.2.9 Health Homes

Attachment 5 – Section 3.2.9, Question 1(SOW 3.2.9, 3.2.9.1, 3.2.9.1.1, 3.2.9.1.2)

Describe your proposed approach for implementing health homes.

Aetna Better Health offers member-centric programs focused on providing care management, care coordination, chronic condition management, behavioral health care, and better health outcomes. Our programs will ***support Integrated Health Homes currently operating in Iowa***:

- Adults and children with persistent mental illness
- Adults and children with at least two chronic conditions or one and at-risk for another
- Adults and children with SUDs

Aetna Better Health will work closely with our providers to reinforce the Health Home model of care approach to help increase access to coordinated care for individuals with chronic conditions. Increasing care coordination through well-defined services will address whole-person care and eliminate barriers to the more traditional delivery of care.

The availability of the Health Home model will serve to provide quality, member-centered care, eliminating the need for members to use the ED as their primary care resource. We will pursue opportunities in underserved areas.

IDENTIFYING PROVIDERS FOR PARTICIPATION AS AN INTEGRATED HEALTH HOME (IHH)

We will work with any groups interested in participating as an IHH. We will also select those providers with demonstration of some enhanced care coordination capability and applicability to the special populations such as those with chronic conditions or SMI/SPMI/SED. We will recognize practice groups as an IHH.

ASSESSING PROVIDER CAPACITY TO PROVIDE INTEGRATED CARE

We will follow the requirements of the State plan amendments. We will work with the provider organization to advance them to the level to provide the services as required.

PROVIDER EDUCATION AND LEARNING OPPORTUNITIES

For providers interested or participating in IHH programs, we will coordinate provider education between Aetna Better Health and the affiliated IHH entity. We will maintain overall provider communication responsibilities; providers participating in IHH will provide program-specific education.

We will use a combination of our existing provider education tools, techniques, and resources to communicate with providers about our IHH initiatives, reinforcing our commitment to care coordination and offering face-to-face meetings.

The Provider Services Department handles the field service and ongoing education and training of our provider community. Each ***Provider Services Representative has a thorough understanding of our operations and programs*** and is well-versed in the Aetna Medicaid Managed Care program overall. Our team will be well-versed in our IHH program.

Our education program begins with the provider orientation process. Upon credentialing approval by Aetna Better Health, we send a welcome letter. Within 30 days of the provider's effective date, a Provider Services Representative will contact the provider's office to schedule an orientation. In our new provider orientation, our local team meets face to face with providers and their staff to introduce the program requirements and initiatives such as IHH and provider incentives.

For current providers, we offer educational forums with in-depth training on rotating topics, and we will include IHH in that rotation. Our Provider Services Representatives also conduct follow-up office visits to reinforce training for providers and their staff. We meet face to face with our providers regularly to build relationships and rapport. To support our in-person training, we publish reference documents such as the provider manual, bulletins, and our quarterly newsletters.

We hold ***Practice Manager's Advisory Committee (PMAC) meetings and various training seminars throughout the year.*** We distribute provider newsletters, along with specialized mailings including

provider manual updates, changes in policies or benefits, and general news and information of interest to our provider community. Providers may also access information on our provider portal. This free online provider portal allows providers to access critical information such as the provider manual, notifications (for example, Notice of Authorization and remittance advice), and network bulletins.

TECHNICAL SUPPORT, INFRASTRUCTURE, TOOLS AND OVERSIGHT TO IHH PROVIDERS TO COORDINATE WITH PCPS

Aetna Better Health will offer a suite of reports and tools for IHH providers to access using our provider portal. The portal offers a single source for providers to gain access to key information that will support them with effectively managing their population and have actionable information at their fingertips to support clinical decision making. The key tools in our IHH provider suite that includes the CORE predictive modeling tool, quality reports, clinical guidelines, and claims and pharmacy information.

ASSESS AND CUSTOMIZE CARE MANAGEMENT BASED ON MEMBER RISK LEVEL

Aetna Medicaid's unique and proprietary CORE predictive modeling system identifies members at high-risk for over-utilization. It provides risk analysis and scoring for members based on claims data (including pharmacy) and other information. The CORE application has been enhanced to include behavioral health markers and increased predictability of risk.

These analyses support effective monitoring and analysis of care coordination, including detecting inappropriate patterns of care that may occur in members with complex health care needs.

CORE evaluates member risk for general risk, ED utilization risk, and inpatient admission risk. CORE presents integrated results and allows users to examine the components contributing to risk. We invite members who are identified as high-risk in key groups within the CORE to participate in care management. We reach out to those members with the highest risk at the first of each month.

Our staff will generate and review the following reports and tools with our IHH providers related to ED use to identify members who may benefit from intensive care management:

- Super-utilizers and high-utilizing members
- ED visits by member and by provider
- ED visits by diagnosis

We perform the following tasks on behalf of members to assess their care management needs, depending on the member's situation:

- Health Risk Questionnaire
- Outreach questionnaire – meets NCQA requirements
- Care Plan interview/Inter-Rai
- Various condition-specific assessments that include disease management needs
- Various behavioral health and functional screeners

PERFORM DATA ANALYTICS ON PERSONAL, MEDICAL, AND PHARMACY DATA

Aetna Better Health has a four-step process to define and monitor for services provided to our members:

1. Analyze data
2. Identify data patterns and trends
3. Address variations in the utilization of services

4. Seek member satisfaction

We compare patterns of health care service utilization compared to known benchmarks. We use measurable performance indicators based on an assessment of evidence-based standards and benchmarks. We sort data by regional and geographic area, provider type, and member age cohorts. Our Medical Management team then uses statistical methodologies to trend data over specific periods.

OUTCOMES TOOLS AND MEASUREMENT PROTOCOLS TO ASSESS IHH CONCEPT EFFECTIVENESS

We will use a suite of reports to provide Medical Management leadership with a comprehensive framework for examining utilization patterns and trends. We compare our utilization performance measure results to targeted benchmarks, such as HEDIS Medicaid 75th percentile, to identify areas for improvement.

Our Chief Medical Officer will review data from these reports with staff across several functional areas, including Care Management, UM, Quality Management, Operations, and Finance. We will then submit recommendations to the QM/UM Committee for consideration and approval.

Our work group uses various data sources to identify unusual patterns of use of service:

- Re-admission rates
- ED utilization rates
- Annual visit rates
- Medication reconciliation
- After-hours access
- HEDIS
- Category of Expense reports, including overall and unit cost metrics
- CORE reports (stratification of member by risk level)

CLINICAL GUIDELINES AND OTHER DECISION SUPPORT TOOLS

Aetna Better Health adopts annually evidence-based, nationally recognized, Clinical Practice Guidelines. We include these guidelines on the provider section of our website. These resources are links to find information about specific treatment types and guidelines. Some examples include:

- Asthma
- Congestive heart failure
- Diabetes
- Depression
- ADHD
- Schizophrenia
- Long-term Care (LTC) residential coordination of services

REPOSITORY FOR MEMBER DATA INCLUDING CLAIMS, LABORATORY, AND CONTINUING CARE DOCUMENT

Two systems serve as the repository for member data. Our member assessment process is supported by a web-based care management business application, which incorporates many of the assessment protocols and requirements in electronic format. The application enables Aetna Better Health staff from other departments who have a business need to review a member's assessment and other key administrative and historical clinical data, such as enrollment history, contact information, diagnosed conditions, prior authorizations, medication history, laboratory results when available, discharge planning notes, and claims history.

At the core of our application architecture is QNXT™, our business application and data management system, which is a rules-based information processing system. QNXT™ modules support all aspects of the claims adjudication process. This system handles claims, eligibility and enrollment processing, service authorization, and provider enrollment and data management functions.

Attachment 5 – Section 3.2.9, Question 2

Describe strategies proposed to increase health homes participation.

Our CORE application and ICM assessment tools are the primary source of information about members with chronic conditions who we would consider referring or reassigning to either a health home or IHH. We will assess members based on the combination of risk groups to which they belong; each member receives a recommended stratification level, which we use to inform the ICM service level for which the member will later be assigned. Those members with chronic conditions or an existing chronic condition with a behavioral health diagnosis will receive a higher stratification level and recommendation for a health home. The entire membership is run through the CORE application.

The CORE listing may not include every member with two more chronic conditions that will benefit by a health home or IHH. We will create new a reporting algorithm to capture those members who meet the criteria. We will engage this membership and recommend they assign themselves to a health home.

Attachment 5 – Section 3.2.9, Question 3

Describe your proposed reimbursement structure for health homes.

Aetna Better Health is committed to developing and expanding innovative payment and incentive models designed to improve quality, reduce costs, transform care delivery, and move beyond the traditional fee-for-service model. We base our approach on a comprehensive Value-based Purchasing (VBP) strategy of highly collaborative relationships with the provider community. Like the other core programs (P4Q, P4P), we will operate our IHH and health home programs to support effective care:

- **Pay-for-Performance (P4P),** which rewards providers if they demonstrate core competencies to provide quality care, enhance access, and improve health outcomes
- **Pay-for-Quality (P4Q),** which rewards providers for achieving better performance on a broad spectrum of HEDIS measures and utilization metrics for their Aetna Better Health member panel

These programs will support effective approaches to care delivery and care coordination, continually improving the quality of care and health outcomes. Our multi-level approach enables providers at any panel size to participate in the program that best matches their practice capability and transformation goals. Because practice transformation and movement to new payment and delivery models can be a time-intensive process, we have established an entry-level program that allows providers with even a single active member to participate.

Aetna Better Health will have Health Home managers who will provide the oversight and education of both IHH and health homes.

Attachment 5 – Section 3.2.9, Question 4

Describe how you will ensure non-duplication of payment for similar services.

We will require that members in health homes and IHHs receive prior authorizations for services. Through the prior authorization process, we will understand where services are already authorized. If a service has already been approved, newly requested duplicate services will be denied, thus preventing rendering and payment for the duplicate service. Our Care Management team will also track trends relating to duplicate requests for services and work with the provider as needed.

The prior authorization process will also prevent anyone assigned to a health home from being assigned to another Patient-centered Medical Home (PCMH) or IHH.

Our claim adjudication system has edits in place to prevent payment of claims for duplicate services. We discuss these edits in more detail in Section 13.

3.2.10 Chronic Condition Health Homes

Attachment 5 – Section 3.2.10, Question 1 (SOW 3.2.10)

Describe how you will fulfill the requirements of this section in addition to the general Health Homes requirements.

Our approach to implementing Chronic Condition Health Homes is the same as that outlined in 3.2.9 for IHHs.

3.2.11 1915(i) Habilitation Program services and 1915(c) Children's Mental Health (CMH) services

Attachment 5 – Section 3.2.11, Question 1 (SOW 3.2.11.1, 3.2.11.2.1, 3.2.11.2.2, 3.2.11.2.6, 3.2.11.2.7, 3.2.11.2.8, 3.2.11.2.10, 3.2.11.2.16)

The Contractor shall deliver the State's 1915(i) State Plan HCBS Habilitation Program Services and 1915(c) CMH Waiver services to all members meeting the eligibility criteria and authorized to be served by these programs. The Contractor shall be responsible for: (i) assessment of needs-based eligibility; (ii) service plan review and authorization; (iii) claims payment; (iv) provider recruitment; (v) provider agreement execution; (vi) rate setting; and (vii) providing training and technical assistance to providers.

Describe your proposed approach for delivering these services.

We have been working with HCBS Habilitation Program Services and 1915(c) CMH Waiver services since inception. We serve individuals eligible for these programs in multiple states.

ASSESSING NEEDS-BASED ELIGIBILITY

Leading up to and immediately after the Operational Start Date, Aetna Better Health will identify members who have the greatest need by reviewing all available information from State-provided claims, program level, and current services, to prioritize those members for assessment. Table 3-7 shows our timeline for assessing and prioritizing members.

Table 3-7: Proactive steps allow us to prioritize members quickly after our Operational Start Date

Timing	Events
Before Operational Start Date	• Review existing initial assessment criteria and tools to identify any additional questions we should use to address the member population. • Load assessment tools into our electronic system. • Hire and train additional staff to handle surge requirements for the first 30 days after Operational Start Date. • Conduct Case Manager training. • Load Agency-supplied claims data into our electronic system. • Review claims and other available data to identify high-risk members for initial outreach.
On Operational Start Date	• Begin contacting members and legally authorized representatives to conduct initial telephone screening. • Load assessment data into ICM system as it is received. • Begin performing Priority 1 face-to-face assessments.
After Operational Start Date	• Schedule and conduct face-to-face assessments based on priority levels.

ACTIVITIES BEFORE THE OPERATIONAL START DATE

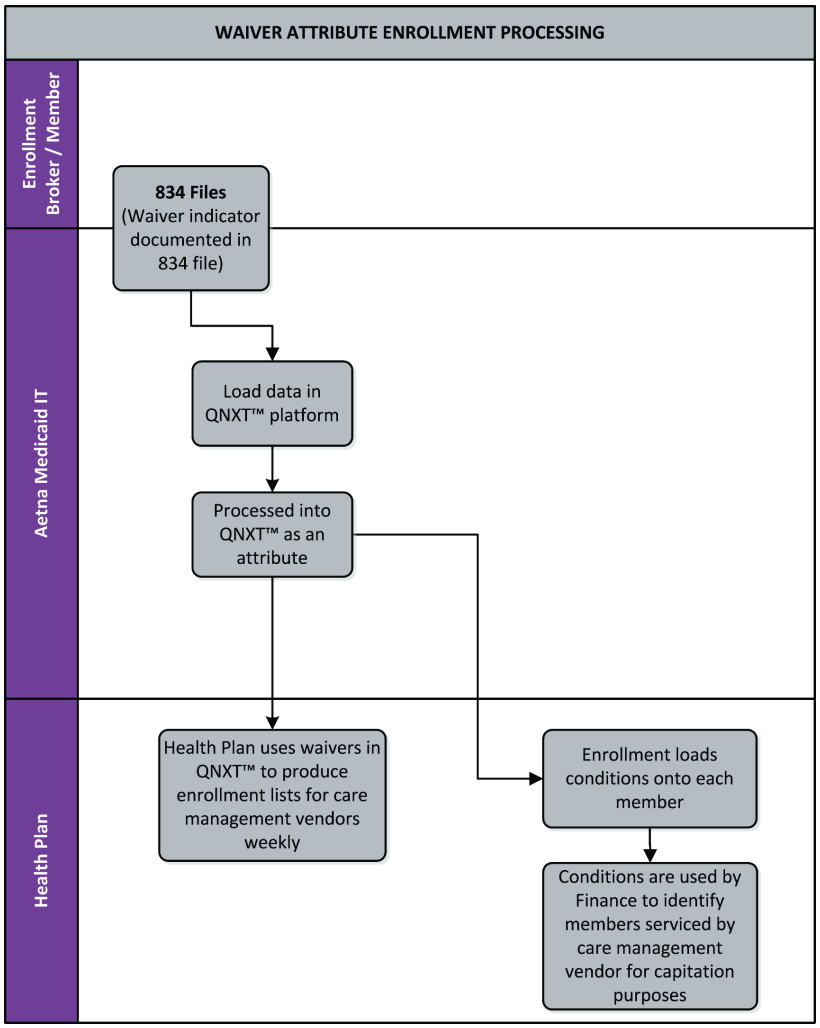
Before the Operational Start Date, we will load information provided by the Agency, including claims information and each member's program level and current services, into our electronic system. Clinical staff from our Care Management team will analyze this data to identify and prioritize members who have the most immediate need for initial member outreach calls. First, we will call members whose medically fragile conditions may put them at greater risk of requiring hospitalization or other acute level services unless we provide close coordination and monitoring. We may also prioritize any member who has been hospitalized during the month before the Operational Start Date. These members will be identified as our first priority and they will begin receiving outreach calls on Day One of the Contract.

ACTIVITIES ON AND AFTER THE OPERATIONAL START DATE

We will receive an enrollment file that contains member information from the Agency or the Enrollment Broker. The 834 enrollment file will contain a waiver attribute indicating the member's type of waiver. We load and process this attribute into QNXT™, our business processing application.

Our Enrollment department loads, or attaches, conditions to the member profile for the Finance Department. Finance uses these conditions for capitation purposes. We also produce weekly reports for Care Management and our Care Management vendors. Care Management uses these reports for assessment purposes. Figure 3-5 shows this process.

Figure 3-5: Waiver attribute enrollment processing



Care Management staff will call members, starting with those identified with the highest needs as the first priority, and continuing on to every member within specified timeframes (unless notified by the member, or member's PCP by telephone or in writing of a more urgent need). We ask the member a set of brief, standardized screening questions. The results of this questionnaire will quickly and objectively help us assign a priority level (1, 2, or 3) for the face-to-face assessment for each member.

ASSESSMENTS

Case Managers use initial and periodic assessments to identify needs, create solutions, and support follow-up action and education. We will use standardized assessments from InterRAI for initial and annual assessment. When a member faces a change (such as physical condition, behavioral condition, family supports, living situation, or age), we will conduct assessments to determine whether the member's Service Coordination level has changed and whether current services and care are still appropriate for the member's needs. The timeframe to complete all comprehensive health risk assessments after initial member enrollment may range from 30 – 120 days.

Members, PCPs, Case Managers, or anyone on the member's care team can request a reassessment to address specific changes. If a member requests a reassessment, we will complete the reassessment within seven calendar days of the request.

Our proposed assessments allow the Case Manager to gather objective and subjective data that will best assess the member's functional, medical, and biopsychosocial status. This information, along with information learned in the interRAI, forms the basis for developing the ISP.

We separate the Care Management team performing the needs assessments from direct service provision to make certain the assessments are conflict free and consistent with Balancing Incentive Program requirements.

Table 3-8 identifies our proposed functional assessment instruments.

Table 3-8: Aetna Medicaid Medical Management—List of available assessments and screening tools

	Applicable 1915(c) and 1915(i) Waiver						
	AIDS /HIV	BI	CMH	EW	I & H	ID	PD
Comprehensive Health Assessments • interRAI Assessment Suite • Severity Index Scoring (SIS)	x	x	x	x	x	x	x
Member Outreach Questionnaires & Assessments • New Member Outreach Questionnaire • Monthly Member Update Assessments	x	x	x	x	x	x	x
Assessments of HCBS Needs and Associated Expenses (HCBS, MFP, Community Transition) • HCBS Needs Tool • Cost-Effective Study	x	x	x	x	x	x	x
Health & safety assessments, screeners, & tools • Contingency/Back Up Plan • Environmental Safety Survey • Re-admission Prevention Assessment • Morisky Medication Adherence Tool	x	x	x	x	x	x	x
Quality of life assessments & screeners • Pain Assessment • Determine Your Nutritional Health Screening Tool	x	x		x	x		x
Mental health screeners • K6-Screener (SMI) • Mini Mental Status Exam (Mental Status)	x	x		x	x		x
Evidence-based condition-specific assessments: • Asthma (adult, pediatric), COPD, Diabetes, HIV, Heart Failure, Hypertension • Cancer, Depression, ESRD, Sickle Cell, Perinatal	x	x	x	x	x	x	x

	Applicable 1915(c) and 1915(i) Waiver						
EPSDT population assessments & screenings • Lead Poisoning Assessment • CRAFFT (Substance Use Disorders Screening) • PSC-17 (Childhood Emotional and Behavioral Problems Screening)	X	X	X		X	X	
Maternal health assessments & screeners • Prenatal Trimester, • Edinburgh Postpartum Depression Screen	X	X	X		X	X	X

SERVICE PLAN REVIEW AND AUTHORIZATION

Aetna Better Health will use Aetna Medicaid's unique ICM program to provide effective, comprehensive care coordination for members who have the highest levels of need. We will engage providers, our members, advocates, community resources, and relevant Iowa agencies, including the Agency, to coordinate physical, behavioral, and social needs of our members. By working with these groups we will see that the components of the service plan process meet contractual requirements as well as state and federal regulations and policies.

Pioneer in Fully Integrated Care

Our ICM approach to care coordination is member-focused rather than disease-focused. It incorporates members' values, needs, and priorities using a culturally sensitive approach. We capitalize on each member's strengths and supports and use motivational interviewing techniques to enhance communication and member engagement. ***ICM manages member care needs by providing a continuum of acute and solution-focused interventions including complex care management, LTSS, and end-of-life assistance***—always aiming to keep members in the most integrated and least restrictive care environment possible.

Collaboratively, we create a Care Plan that includes mutually agreed, member-centered goals and actions. The Case Manager and the care team arrange for both covered and non-covered services to be coordinated for the member. The Care Plan identifies services and supports that can be provided by the member, his or her family or caregivers, community supports, community-based Case Managers, providers, and practitioners.

Through our guideline-supported care management system, we encourage all members to follow age-appropriate screening and health-maintenance guidelines as well as evidence-based care for chronic physical and behavioral illnesses. Every assessment and encounter includes attention to comorbidities and to reducing unhealthy behaviors (such as tobacco use or SUD) in a member-centered manner.

CLAIMS PAYMENT AND PROCESSING

Fully integrated for optimal efficiency, our customized platform addresses the dynamic demands of the Medicaid population using industry-recognized claims management code auditing software solutions.

Quality and Value through Simple, Relevant Solutions

Through these highly configurable systems, we can make rapid adjustments to meet changing demands of program strategy, tactics, and other policy changes. The knowledge of our staff, combined with the flexibility of our platform, enables us to deliver a tailored Medicaid benefit management program that will readily adapt to Iowa initiatives.

Although we strongly encourage electronic filing of claims, we accept claims submitted in both electronic and paper form from our providers. Multiple clearinghouses offer electronic claims submission, providing a broad range of submission options for our providers. We pay providers using electronic funds transfers that deposit funds directly into the provider's bank account.

PROVIDER RECRUITMENT

We will monitor our network regularly to verify that every member has reasonable access to services and supports they need. We are developing enhanced policies, procedures, and processes to monitor our provider, subcontractor, and affiliate networks to provide adequate network capacity, accessibility for our members, and accuracy in our provider listings. Our goal will be to meet and exceed Agency requirements for access.

Our network will include PCPs, specialist physicians, mental health providers, SUD providers, hospitals, pharmacies, and other ancillary service providers.

PROVIDER AGREEMENT EXECUTION

Through network provider contracts drafted by our Legal Department, we will set our expectations and policy requirements with all providers through detailed, written, and signed contracts. These contracts meet the requirements in 42 CFR 438.206, 42 CFR 434.6, and as detailed in Attachment 1 to the RFP Sections 2.2 and 6.1.2. Our Legal Department will review any changes requested by our providers to our network provider contracts.

PROVIDER TRAINING AND TECHNICAL ASSISTANCE

Aetna Better Health is committed collaborating with child welfare, juvenile justice providers, and community providers to develop effective trainings, interventions, and supports to respond effectively to needs of children and adolescents with behavioral health issues. We will expand our training audience to include pediatric and dental providers who work with this population, foster parents, and the Department of Education. We welcome the opportunity to participate in the Agency's Child Welfare Provider Training Academy.

We will work with our State and community partners to develop concise and appropriate training focused on building collaborations with families that respect the family's unique culture, values, motivations and goals, with an emphasis to learn about meeting the child or adolescent and their family "where they are" to facilitate discovering their strengths and identifying the support necessary for the child/adolescent to implement learned skills so they can reside successfully in a natural home and community-based setting.

We will provide accessible, relevant, skill-based training across Iowa through instructor-led presentations, webinars, online training modules, and educational materials on our website. In addition to using our Aetna Better Health clinical staff and Behavioral Health Medical Director, we will actively seek out Iowa Behavioral Health community leaders to assist in training program development and presentations. We would engage in community forums in which providers, members, and families would be active participants in content development and presentations.

Training modules will cover a wide range of topics including adverse childhood experiences; trauma-informed care; child and family team; transition planning; service/treatment planning; supports intensity scale; and lesbian, gay, bisexual, and transgender support topics. Our goal is to leverage the experience of family peers to review and provide feedback of our training materials.

Provider specific topics will include how to use data to define outcomes, monitor performance, promote health and well-being and provide education activities to promote the use of evidence-based practices.

We will work with our clearinghouse partners, such as Emdeon, to offer web-based tools to enter claims data in an easy-to-use in interface.

Attachment 5 – Section 3.2.11, Question 2

Describe your experience serving similar populations, if any

Aetna Medicaid has ***30 years of experience in managing the care of vulnerable populations***, such as those that are part of the 1915(i) HCBS Habilitation Program Services and 1915(c) CMH Waiver services currently offered in Iowa. ***We support members in 13 states, including Arizona, Florida, Illinois, Kentucky, Louisiana, Maryland, Michigan, Nebraska, New Jersey, New York, Ohio, Pennsylvania, and Virginia.*** The population groups and member numbers are as follows:

- **Aged, Blind, Disabled (ABD) –** 190,976 members
- **Dual Eligible –** 48,239 members
- **Long Term Support Services –** 24,894 members
- **Severely mentally ill –** 19,000 members
- **Intellectually/Developmentally or Developmentally Disabled –** 10,250 members

3.2.12 Family planning services

In accordance with 42 CFR 431.51(b)(2), members shall not be restricted in freedom of choice of providers of family planning services. Therefore, members shall be permitted to self-refer to any the Agency Medicaid provider for the provision of family planning services, including those not in the Contractor's network.

We understand and will follow this requirement.

3.2.13 Iowa Health and Wellness Plan benefits

Attachment 5 – Section 3.2.13, Question 1

Describe how your proposed approach will ensure Medically Exempt members will receive State Plan benefits.

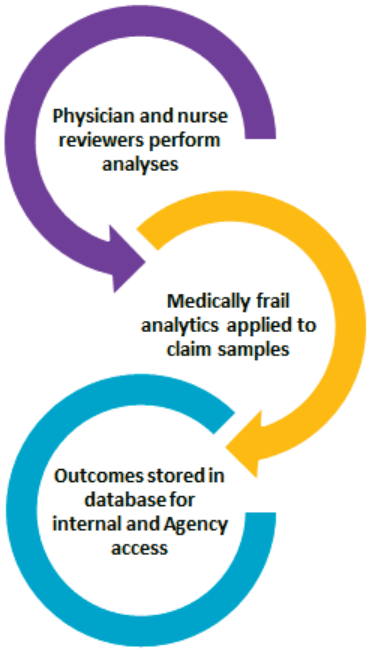
Committed to Health Care Transformation in Iowa

We currently have identification measures in place to identify medically exempt members in the Iowa Health and Wellness Plan (IHAWP) program. Going forward, we will incorporate that same approach to identify medically exempt members and move them from the Iowa Health and Wellnes Plan benefit package to the Medicaid benefit package and will coordinate that transition with the agency.

Attachment 5 – Section 3.2.13, Question 2, (SOW 3.2.13.1.1)

Describe your proposed strategies for implementing retrospective claims analysis to determine if a member is Medically Exempt.

We recently implemented retrospective claims analysis to identify medically exempt members. At the time we performed the analysis, there were 10 months of paid Iowa Health and Wellness Plan claims. We identified approximately 2,000 members as potentially medically exempt.



We created two tiers stratified by cost:

- **Higher cost tier –** We were able to identify 41% of the members as medically exempt
- **Lower cost tier –** We were able to identify 3.5% of the members as medically exempt

We developed internal analytics to match the criteria for the Iowa Medically Frail and added additional behavioral health and substance use disorders codes to help identify any member who might be eligible. In addition, we reviewed all high-cost claims separately and any member with high pharmacy spend or categories of high-cost specialty medications.

We are currently doing retrospective analysis as well as real-time identification of members; we have two senior-level physicians performing the reviews, and one is specifically focused on behavioral health issues.

We will submit our list of members who meet medically exempt criteria monthly.

3.2.14 Value-Added Services - CONFIDENTIAL

Attachment 5 – Section 3.2.14, Question 1 (SOW 3.2.14, 3.2.14.1, 3.2.14.2, 3.2.14.3, 3.2.14.4) - CONFIDENTIAL

1. Describe any proposed Value-Added Services. Include in the description:

a. Any limitations, restrictions, or conditions specific to the Value-Added Services;
b. The providers responsible for providing the Value-Added Service;
c. How the Value-added Service will be identified in administrative (encounter) data;
d. How and when providers and members will be notified about the availability of such Value-Added Services while still meeting the federal marketing requirements; and
e. How a member may obtain or access the Value-Added Services.

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Attachment 5 – Section 3.2.14, Question 2 - CONFIDENTIAL

2. Provide any applicable data on improved outcomes linked to Value-Added Services you have implemented in other states.

[redacted]

3.3 Continuity of Care (SOW 3.3.1, 3.3.2, 3.3.3, 3.3.4)

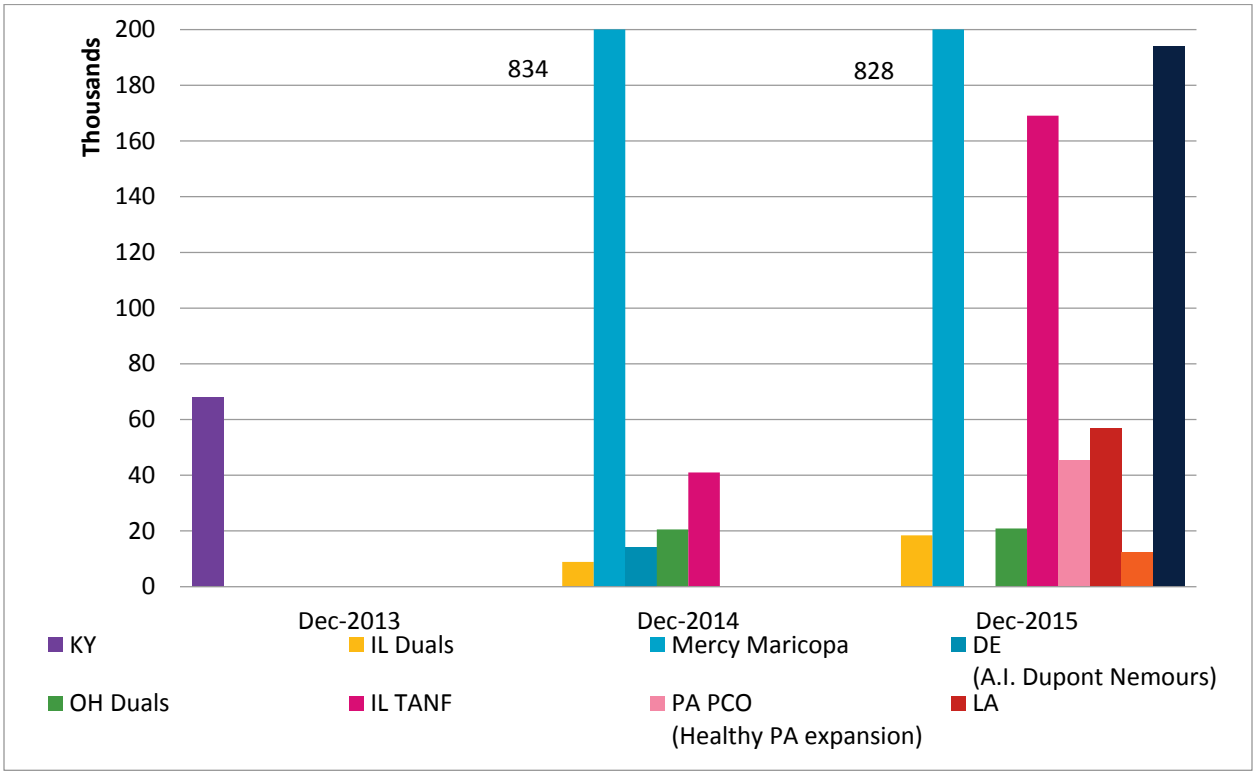
Attachment 5 – Section 3.3, Question 1

Describe your strategies to ensure the continuity of care of members transitioning in and out of the program, and transitioning between Contractors and funding streams.

To facilitate member transitions and continuity of care, Aetna Better Health will see that **all** members receive optimal, uninterrupted health care, regardless of whether they enroll as new members, transition out of the program, or between funding streams. Aetna Better Health's health plans have a history of facilitating compassionate and efficient care transitions for members. Continuity of care for members poses challenges related to any active course of treatment they are receiving. We strive to make it as seamless as possible for the member.

In the last year, we have successfully transitioned members in the states of Louisiana, Illinois, Kentucky, and Arizona as part of program implementations. Figure 3-6 shows the programs and membership numbers for each of these states.

Figure 3-6: Implementation membership numbers



We will develop transition of care policies that follow all State and federal requirements. To implement these policies, we will:

- Train staff from all involved departments, including Member Services, Medical Management, Quality Management, Provider Services, and Care Management, on the policies
- Train PCPs and IHHs on our transition policies and publish these policies on our website
- Notify members of our transition processes in our new member materials and encourage them to contact Member Services for assistance with care transitions

Conversion planning process for new members entering the program

We will use the daily, weekly, and monthly enrollment files from the enrollment broker to process eligibility within 24 hours of receipt for enrollment, re-enrollment, or disenrollment. To start the member transition process, we will receive information on the daily enrollment files from the Enrollment Broker, such as:

- Name, addresses, and telephone numbers of all new members
- Indicator for individuals who are automatically assigned
- Name, telephone number, and after-hours telephone number of the selected PCP if the member has made an affirmed choice
- For automatic assignments, the name of the most recent or current PCP
- Indicator for members who have self-identified as having special needs or are pregnant

We will receive from the Agency claims data and information regarding existing or ongoing treatment or Care Plans when a member joins our plan. We will use that data to promote continuity of care.

If a new member is transitioning to our health plan and is already receiving an active course of treatment, we will allow for continuous care for up to 60 days. During this period, we will not require prior authorization for continuation of medically necessary services regardless of whether the services are being performed by an in-network or out-of-network provider.

For members with special health care needs, we will continue medically necessary services for up to 60 calendar days or until we can reasonably transfer the member without disruption, whichever period is shorter. To minimize disruption of members during this time, we will pay all clean claims for covered services, without verifying authorization, for 30 days after the enrollment effective date.

We will also follow continuity of care guidelines as required for the following categories:

- Pregnant Women
- Preconception/Inter-conception Care
- Pharmacy Services
- Behavioral Health
- Durable medical equipment (DME), Prosthetics, Orthotics, and Certain Supplies

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Conversion planning process for members transitioning out of our plan

Our Care Management team is available to discuss specific members who have special needs or at higher risk to facilitate ongoing appropriate services with the member's new health plan and providers.

We will promptly respond to all requests from receiving health plans for copies of appropriate medical records and case management files at our expense. Additionally, we will educate our PCPs on their responsibility to send a copy of the member's medical record and supporting documentation within 10 business days of the receiving health plan's PCP's request.

If the member is hospitalized during the transition to another health plan, we will continue to process and pay claims related to the hospitalization event until the member is discharged. Our Case Managers will coordinate with the hospital discharge staff and the receiving health plan to assist with the transfer of information and support to minimize gaps in care and enable a smooth transition.

Plan to meet transitions between program contractors and funding streams

Our goal is to support a member's transition with no gaps in services. For members who transition to another contractor or a waiver program outside of Medicaid managed care, we will work with the Agency and the receiving contractor to foster continuity of care.

We will also continue to submit prior claim encounter adjustments after the member leaves our plan as appropriate. Also, our Care Management team will be available to discuss specific members who have special needs or at higher risk to facilitate ongoing appropriate services in the new contractor environment.

For members transitioning out of the plan due to a cause listed in Section 7.4.1 of the SOW, we will follow the same process as any other member transitioning out for other reasons.

In 2014, we made a business decision to exit the Delaware market. The state agency determined that our entire membership was transferring to a single payer.

Our Case Managers worked tirelessly to compile stratified case summaries and updated assessments that were transferred to the other payer. We conducted meetings with the State to review and approve our transition plans and successfully transitioned all of our members effective January 1, 2015.

Additionally, we chose to extend the services of some of our staff beyond the transition date to provide ongoing support services.

Prior authorizations

To prevent interruption of members' primary care, obstetric care, specialty, or behavioral health care, home health, or DME services during the transition period, we will authorize otherwise qualified, out-of-network providers to continue rendering medically necessary, covered services to the member until those providers become part of the our network, the course of treatment has been completed, or care can be safely transferred to an appropriate network provider. We will concurrently work with the provider to encourage them to join our network. Authorization for medically necessary, **covered out-of-network services will continue for up to 90 days** or until the member has completed an ongoing course of treatment, whichever is shorter.

Pregnancy continuity of care

When a new member is pregnant at the time of enrollment and has 12 weeks or less remaining before her expected delivery date, we will authorize out-of-network services for the delivery and up to six

weeks of postpartum care. If a member wants to change her OB/GYN provider, she may do so even in her last trimester if an in-network provider agrees to accept her. Our Service Coordinator and a Provider Services Representative will work with the OB/GYN provider to facilitate this process.

3.4 Coordination with Medicare

Attachment 5 – Section 3.4, Question 1 (SOW 3.4)

Describe your proposed approach and strategies for coordinating care for duals (members with both Medicare and Medicaid coverage).

Experience with dual-eligible members

Aetna Better Health will apply our knowledge, expertise, resources, and the best industry practices to develop pharmacy cost sharing, a complementary Medicaid benefit package, and quantifiable and qualitative reporting. Aetna Medicaid subsidiaries in three states support 41,638 dual-eligible members. Notably, our dual-eligible member experience, as shown in detail below, includes:

- Managed Medicaid dual-eligible members with 28,484 members in two states
- Dual-eligible Special Needs Plans with 13,154 members in one state
- Dual-eligible and LTSS with 3,407 members in Delaware through the state's intensive long term care management program
- Arizona Long-Term Care System (ALTCS), where we administer a plan that provides LTSS to 11,822 members, 81% of whom are also dual-eligible members

Care coordination strategies for dual-eligible members

Aetna Better Health will provide care coordination to our dual-eligible members. Our experience in other states gives us the ***ability to coordinate care for dual-eligible members with waiver, home-based, and other services***, effectively exchanging relevant information with members, providers, the health plan, and the Agency. Our strategy to drive cost-effective care and quality improvement for potential members who are eligible for Medicare and Medicaid will leverage our experience and knowledge serving members who qualify for the Medicare payers and Medicare Advantage plans.

We will coordinate services to make it seamless as possible. We will see the member goes to an in-network Medicare provider. If we get a claim from Medicare as out-of-network, we as primary coordinate payment for medically necessary services with the primary payer for out-of-network provider.

Attachment 5 – Section 3.4, Question 2

Explain how your staff will be trained to assist dual-eligible members with questions about benefits, appeals, grievances, and other topics where Medicare and Medicaid policies may differ.

Member Services Representatives trained to assist dual-eligible members

Aetna Better Health requires our ***Member Services Representatives to be educated, experienced, and trained to fulfill position functions before they have contact with members*.** We prioritize a thoughtful, tailored approach to member service that adheres to performance standards, while properly educating members on their available health care options. Our MSRs benefit from a user-friendly, comprehensive orientation and an ongoing training curriculum to accommodate diverse learning styles. As described in detail below, we incorporate dual-eligible requirements and considerations to address the unique needs of this population.

New Member Services Representatives must complete three weeks of initial training. The first week will cover orientation, a program overview, and Medicaid principles, and basic requirements such as confidentiality, including HIPAA safeguards and compliance. We then move into job-specific information, including:

- Eligibility policy – member benefits and health plan information
- ***Member rights and responsibilities under the Medicare and Medicaid programs***
- Coordination of benefits responsibilities and requirements
- Grievance and appeals policies and procedures for members
- Techniques to recognize and report suspected provider fraud and abuse
- Open enrollment for members

New Member Services Representatives begin receiving calls during their third week of training and managers closely monitor them for exemplary member service. Monitoring continues, to a lesser degree, throughout their tenure with us. We use a combination of case scenarios and assessments to measure the learning objectives outlined above. The staff complete an attestation they received training and can accurately address any member and or provider benefits inquiries, answer member and provider grievance and appeals questions, and locate and use Medicaid and Medicare policies and procedures.

The Aetna Learning Resource Library contains 50 Medicare courses covering topics such as:

- **Functional training**
- **Grievance and appeals**
- **COB**

As reference materials, the staff has access to a learning and performance website that includes self-paced activities, training vignettes, training videos, and a calendar of additional training. For reinforcement, training information is available in our member handbook and provider manuals and on our website.

Our Care Management staff has the training and experience

The Care Management staff complete training in a variety of topics designed to enhance their expertise to coordinate difficult care situations and respond to members who have complex medical needs or comorbid chronic illnesses. ***Any staff member that interacts with a member that has Medicare coverage of any type is required to take annual courses through the Learning Resource Library.*** Aetna Better Health Case Managers will receive training in a variety of topics designed to enhance their expertise with these members, including:

- Medicare University on our Learning Resource Library
- Assessing member needs and care planning
- Assessment member needs for supportive care management
- Case formulation, root cause identification, and care planning
- Focusing on the right member
- Identifying gaps in care

We also provide training to providers, professional associations, advocacy groups, hospital staff, and related organizations within each Service Area.

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Section 4: Long Term Services and Support

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SECTION 4 – LONG TERM SERVICES AND SUPPORTS

Below is a table that outlines how the Scope of Work provided in RFP Attachment 1 relates to the responses to the questions provided in RFP Attachment 5. We provide this table to reduce redundancy of responses and information and to simplify the evaluation process for the evaluators.

For requirements in Attachment 1 that do not require a detailed response, the table below indicates our intent to comply with the stated requirement in lieu of repeating the RFP question and including a will comply statement within the body of the narrative.

Attachment 1 requirement	Cross-reference to Attachment 5	Will comply
4.1 General	Attachment 5 – Section 4.1, Question 1, 2, Section 4.3, Question 9	Yes
4.2 Level of Care and Support Assessments	Attachment 5 – Section 4.2, Question 1 & 4	Yes
4.2.1 Initial Determination for Non-Members	Attachment 5 – Section 4.2, Question 1	Yes
4.2.2 Level of Care Assessments and Annual Support Assessments	Attachment 5 – Section 4.2, Question 1 & 3	Yes
4.2.2.1 Identification	Attachment 5 – Section 4.2, Question 1	Yes
4.2.2.2 Initial Assessment and Annual Support Assessment	Attachment 5 – Section 4.2, Question 1 - 4	Yes
4.2.2.3 Documentation Requirements	Attachment 5 – Section 4.2, Question 1 & 4	Yes
4.2.2.4 Pre-admission Screening and Resident Review	Attachment 5 – Section 4.2, Question 1	Yes
4.2.3 Appearance of Ineligibility	Attachment 5 – Section 4.2, Question 1	Yes
4.2.3.1 Waiting List	Attachment 5 – Section 4.2, Question 1	Yes
4.2.3.1.1	Attachment 5 – Section 4.2, Question 1	Yes
4.2.3.1.2	Attachment 5 – Section 4.2, Question 5	Yes
4.3 Community-Based Case Management Requirements	Attachment 5 – Section 4.3, Question 1	Yes
4.3.1 Community-Based Case Manager Qualifications	Attachment 5 – Section 4.3, Question 2 & 3	Yes
4.3.2 External Communication and Coordination	Attachment 5 – Section 4.3, Question 4	Yes
4.3.3 Internal Contractor Communications	Attachment 5 – Section 4.3, Question 5	Yes
4.3.4 Changes in Community-Based Case Managers	Attachment 5 – Section 4.3, Question 6	Yes
4.3.5 Discharge Planning	Attachment 5 – Section 4.3, Question 7	Yes
4.3.6 In-Person Requirements	Attachment 5 – Section 4.3, Question 1	Yes
4.3.7 Response to Problems and Issues	Attachment 5 – Section 4.3, Question 8	Yes
4.3.8 Community-Based Case Management Monitoring	Attachment 5 – Section 4.3, Question 8	Yes
4.3.8.1	Attachment 5 – Section 4.3, Question 8	Yes
4.3.8.2	Attachment 5 – Section 4.3, Question 8	Yes
4.3.8.3	Attachment 5 – Section 4.3, Question 8	Yes
4.3.8.4	Attachment 5 – Section 4.3, Question 8	Yes

Attachment 1 requirement	Cross-reference to Attachment 5	Will comply
4.3.8.5	Attachment 5 – Section 4.3, Question 8	Yes
4.3.8.6	Attachment 5 – Section 4.3, Question 8	Yes
4.3.8.7	Attachment 5 – Section 4.3, Question 8	Yes
4.3.8.8	Attachment 5 – Section 4.3, Question 8	Yes
4.3.8.9	Attachment 5 – Section 4.3, Question 8	Yes
4.3.8.10	Attachment 5 – Section 4.3, Question 8	Yes
4.3.8.11	Attachment 5 – Section 4.3, Question 8	Yes
4.3.8.12	Attachment 5 – Section 4.3, Question 8	Yes
4.3.8.13	Attachment 5 – Section 4.3, Question 8	Yes
4.3.8.14	Attachment 5 – Section 4.3, Question 8	Yes
4.3.9 Admissions	Attachment 5 – Section 4.3.12, Question 1 & 2	Yes
4.3.10 Transitions between Facilities	Attachment 5 – Section 4.3.12, Question 2	Yes
4.3.11 Implementation	Attachment 5 – Section 4.3, Question 9	Yes
4.3.12 Nursing Facilities & ICF/IDs	Attachment 5 – Section 4.3.12, Question 2	Yes
4.3.12.1 Case Management Requirements	Attachment 5 – Section 4.3.12, Question 1 & 3	Yes
4.3.12.2 Client Participation Assistance	Attachment 5 – Section 4.3.12, Question 2	Yes
4.3.12.3 State Resource Centers	Attachment 5 – Section 4.3.12, Question 2	Yes
4.3.12.3.1	Attachment 5 – Section 4.3.12, Question 2	Yes
4.3.12.3.2	Attachment 5 – Section 4.3.12, Question 2	Yes
4.3.12.3.3	Attachment 5 – Section 4.3.12, Question 2	Yes
4.3.12.3.4	Attachment 5 – Section 4.3.12, Question 2	Yes
4.3.12.3.5	Attachment 5 – Section 4.3.12, Question 2	Yes
4.3.12.3.6	Attachment 5 – Section 4.3.12, Question 2	Yes
4.3.12.4 Diversion Strategies	Attachment 5 – Section 4.3.12, Question 4	Yes
4.3.12.5 Community Transition Activities	Attachment 5 – Section 4.3.12, Question 5 & 6	Yes
4.3.12.6 Post Transition Monitoring	Attachment 5 – Section 4.3.12, Question 5	Yes
4.3.12.7 Utilization Review	Attachment 5 – Section 4.3.12, Question 2	Yes
4.4 1915(c) HCBS Waivers		Yes
4.4.1 Overview	Attachment 5 – Section 4.4, Question 1	Yes
4.4.2 Service Plan Development	Attachment 5 – Section 4.4, Question 1	Yes
4.4.2.1 Frequency	Attachment 5 – Section 4.4, Question 1	Yes
4.4.2.2 Person-Centered Planning Process	Attachment 5 – Section 4.4, Question 1	Yes
4.4.2.2.1	Attachment 5 – Section 4.4, Question 1	Yes
4.4.2.2.2	Attachment 5 – Section 4.4, Question 1	Yes

Attachment 1 requirement	Cross-reference to Attachment 5	Will comply
4.4.2.2.3	Attachment 5 – Section 4.4, Question 1	Yes
4.4.2.2.4	Attachment 5 – Section 4.4, Question 1	Yes
4.4.2.2.5	Attachment 5 – Section 4.4, Question 1	Yes
4.4.2.2.6	Attachment 5 – Section 4.4, Question 1	Yes
4.4.2.2.7	Attachment 5 – Section 4.4, Question 1	Yes
4.4.2.2.8	Attachment 5 – Section 4.4, Question 1	Yes
4.4.2.2.9	Attachment 5 – Section 4.4, Question 1	Yes
4.4.2.2.10	Attachment 5 – Section 4.4, Question 1	Yes
4.4.2.2.11	Attachment 5 – Section 4.4, Question 1	Yes
4.4.2.2.12	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3 Service Plan Content	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3.1.1	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3.1.2	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3.1.3	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3.1.4	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3.1.5	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3.1.6	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3.1.7	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3.1.8	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3.1.9	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3.1.10	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3.1.11	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3.1.12	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3.1.13	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3.1.14	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3.1.15	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3.1.16	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3.1.17	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3.2 Emergency Plan Requirements	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3.3 Supported Community Living	Attachment 5 – Section 4.4, Question 1	Yes
4.4.3.4 Refusal to Sign	Attachment 5 – Section 4.4, Question 1	Yes
4.4.4 Compliance with Home and Community-Based Setting	Attachment 5 – Section 4.4, Question 3	Yes
4.4.5 Disenrollment	Attachment 5 – Section 4.4, Question 3	Yes
4.4.5.1 Minimum Service Requirements	Attachment 5 – Section 4.4, Question 3	Yes

Attachment 1 requirement	Cross-reference to Attachment 5	Will comply
4.4.5.2 Service Needs	Attachment 5 – Section 4.4, Question 3	Yes
4.4.5.3 Receipt of Long Term Care	Attachment 5 – Section 4.4, Question 3	Yes
4.4.6 Frequency of Community-Based Case Manager Contact	Attachment 5 – Section 4.3, Question 1	Yes
4.4.7 Monitoring Receipt of Services	Attachment 5 – Section 4.4, Question 4	Yes
4.4.8 Self-Direction	Attachment 5 – Section 4.4, Question 5	Yes
4.4.8.1 General Responsibilities	Attachment 5 – Section 4.4, Question 5	Yes
4.4.8.2 Self-Assessment	Attachment 5 – Section 4.4, Question 5	Yes
4.4.8.3 Documentation	Attachment 5 – Section 4.4, Question 5	Yes
4.4.8.4 Use of Representatives	Attachment 5 – Section 4.4, Question 5	Yes
4.4.8.5 Support Brokers	Attachment 5 – Section 4.4, Question 5	Yes
4.4.8.6 Financial Management Services	Attachment 5 – Section 4.4, Question 5	Yes
4.4.8.7 Back-Up Plan	Attachment 5 – Section 4.4, Question 5	Yes
4.4.8.8 Budget	Attachment 5 – Section 4.4, Question 5	Yes
4.4.8.9 Payment	Attachment 5 – Section 4.4, Question 5	Yes
4.4.8.10 Services Pending Implementation of Self-Directed Services	Attachment 5 – Section 4.4, Question 5	Yes
4.4.8.11 Provider Qualifications and Employment Agreement	Attachment 5 – Section 4.4, Question 5	Yes
4.4.8.12 Training	Attachment 5 – Section 4.4, Question 5	Yes
4.4.8.13 Monitoring	Attachment 5 – Section 4.4, Question 7	Yes
4.4.8.14 Disenrollment from Self-Direction	Attachment 5 – Section 4.4, Question 5	Yes

4.1 General

Please explain how you propose to execute Section 4 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience. Provide any relevant data regarding member or provider satisfaction with MLTSS programs you operate in other states.

Our Proposed Program

Aetna Better Health® of Iowa (Aetna Better Health) will use Aetna Medicaid's Integrated Care Management (ICM) program to support management of Iowa Medicaid members receiving Long Term Services and Supports (LTSS). The ICM program meets the care coordination needs of members holistically, including behavioral, physical, and psychosocial needs. We first identify members' goals and then collaborate with them to offer services that meet their needs, while improving their health. We commit to working with Iowa to rebalance LTSS services: we will help move members out of institutions and into the community, divert admissions to facilities, and increase use of the right services necessary to ***help members live successfully in the community of their choice***.

Our ICM approach identifies the most biopsychosocially complex and vulnerable members with whom we have an ***opportunity to make a significant difference***. We engage these members in care

management programs to remove or lessen barriers that limit their ability to manage their own health and well-being. We educate them about their chronic conditions and help them remain in or move to the least-restrictive and most integrated community setting. We focus on their preferences; needs; safety; burden of illness; and availability of family, caregivers, or other supports. We coordinate services consistent with each individual's personal and cultural values, beliefs, and preferences to help them develop resiliency, move toward recovery, and reach their self-defined level of optimal functioning.

We discuss the ICM program in depth in Section 9, Care Coordination, and in our response to Attachment 5, Item 4.1, Question 1 below. Here, we discuss the experience and capabilities of Aetna Medicaid serving members with LTSS needs; show the results of several LTSS programs; provide an overview of our strategy to serve these members in Iowa; and discuss how Aetna Better Health will implement the transition to managed care for these vulnerable members.

We have the experience – Three decades of caring

Three Decades of Caring for Those Most Vulnerable

Aetna Better Health will build on our health plans' 30 years of experience in serving LTSS members in Arizona, Florida, Illinois, Michigan, New Jersey, New York, and Ohio to create a program of individually tailored service coordination and exceptional customer service for members, caregivers, and providers in our Iowa LTSS population. Aetna Medicaid ***owns or operates seven fully capitated Medicaid health plans serving approximately 25,000 members in need of LTSS*** (including home- and community-based [HCBS] and institutional services), developmentally disabled adults and children, physically disabled adults and children, children with special health care needs, the frail elderly, and individuals with behavioral health needs.

Our health plans have refined their approach to serving highly complex and frail populations with diverse benefits. For example, Arizona Aetna Medicaid manages LTSS for 11,862 members, 81% of whom are also dual-eligible members. These services include personal care and private duty nursing; durable medical equipment (DME) and supplies; occupational, physical, respiratory, and speech therapies; supported employment; and physical and behavioral health services. Our experience will enable us to build a managed LTSS program and successfully transition members into the program for the Iowa Department of Human Services (the Agency).

We will save money and improve outcomes in Iowa

Our LTSS Care Management Program will:

- **Help members live in the communities of their choice:** We offer options counseling to every LTSS member and have programs to transition members from institutions to the community. Our LTSS Care Management staff actively works with local housing authorities and the Money Follows the Person (MFP) liaison to coordinate subsidized housing resources for eligible LTSS members.
- **Focus on the whole person through our ICM approach**: Our Aetna Better Health Integrated Care Management Program is a holistic, biopsychosocial, member-centered approach that offers interdisciplinary support to our most complex members. Our care management activities integrate physical, behavioral, and social services to create cost-effective solutions that help members live in the communities they choose.

  Pioneer in Fully Integrated Care
- **Incorporate support from communities:** We will engage with members' existing support systems in Iowa and build on these existing relationships. We will collaborate with targeted Case Managers and community resources to offer seamless services for members.

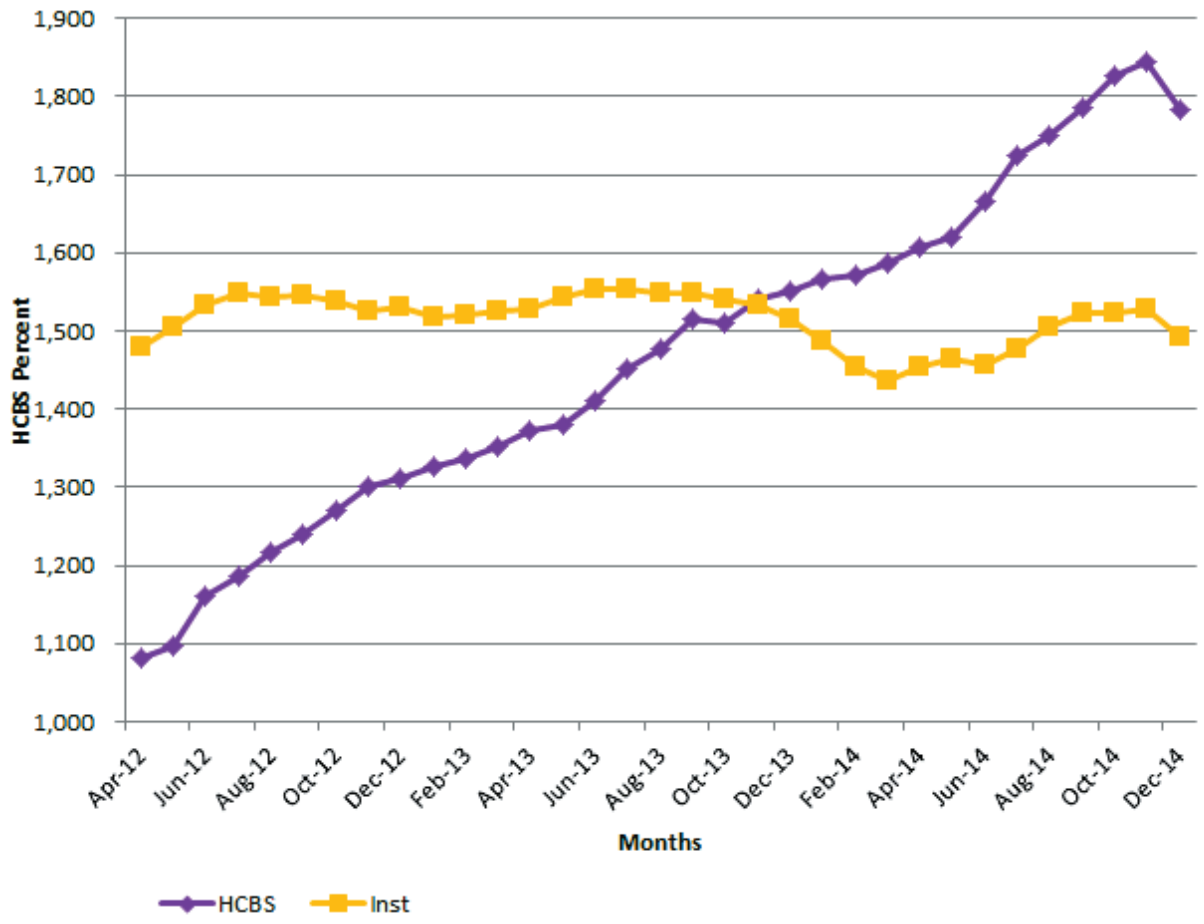
- **Use our proven tools and systems:** We will use our integrated information management tools to identify members, capture information relevant to care, share with providers, and monitor our program effectiveness.
- **Identify opportunities for improvement:** As the claims payer for all benefits, we use rich information to understand the member's health, behavioral health, pharmacy, and Long Term Services and Supports (LTSS) needs to identify opportunities to address care gaps and enhance community living.
- **Generate cost savings:** by providing appropriate use of services, focusing specifically on rebalancing services away from institutional care and in favor of HCBS.

Results from our Plans demonstrate LTSS program successes

Cost Savings

Our LTSS and HCBS programs focus on helping the member live successfully in the community, based on the member's choice. Our results in Delaware, shown in Figure 4-1 below, demonstrate our ability to increase use of HCBS while decreasing use of institutional facilities. **Aetna successfully improved the HCBS ratio by approximately 7% over two years, resulting in a $13 million savings.**

Figure 4-1: Delaware LTSS rebalancing since program start



Member Satisfaction

Our results on the standard CAHPS® (registered trademark of the Agency for Healthcare Research and Quality) survey place us consistently above average in member satisfaction ratings. We are consistent in the top half of plan performance and are at or exceed the 75th percentile. Highlights of the performance of our various LTSS programs are as follows:

CAHPS® results from 2013 Delaware Medicaid/LTSS

- **Rating of All Health Care** 91.3%
- **Getting Needed Care** 85.2%

CAHPS® results from 2013 Arizona Special Needs Plan

- **Customer Service** 87.3%
- **Getting Care Quickly** 81.8%
- **Rating of Specialist Seen Most Often** 78.5%

Independent Analysis: **A 2012 analysis by Avalere Health showed that Mercy Care Plan members, after adjustment for risk, made higher use of preventive/ambulatory services and had lower rates of inpatient utilization, Emergency Department (ED) utilization, and all-cause re-admissions relative to patterns of care for dual eligibles enrolled in Original Medicare (FFS). Specifically, when compared to the total national FFS dual eligibles and adjusted to match the risk of the FFS dual eligibles, the total Mercy Care population exhibited:**

- **3% higher proportion of members accessing preventive/ambulatory health services**
- **31% lower discharge rate (as a measure of inpatient utilization)**
- **43% lower rate of days spent in the hospital (as a measure of inpatient utilization)**
- **19% lower average length of stay (as a measure of inpatient utilization)**
- **9% lower rate of ED visits**
- **21% lower re-admission rate**

Our Aetna Medicaid LTSS member satisfaction surveys show:

- 93% agreed their Case Manager treated them with respect
- 93% agreed they worked as a team
- 93% agreed they trusted their Case Manager
- 93% agreed they had positive results working with their Case Manager
- 97% agreed they were satisfied with the services that their Case Manager provided
- 93% agreed to share survey information with their Case Manager

We coordinate complex benefits

We have the experience to successfully manage the varying benefits, cost shares, and eligibility requirements of the Iowa LTSS and HCBS waiver populations. We will adapt our information-rich, collaborative, person-centered process to the unique needs of Iowans and will be accountable for meeting the requirements specified by the Agency. We have the experience to do so: Two of our four LTSS plans (the Arizona and Illinois plans) provide integrated LTSS, physical health, and behavioral health benefits; all of our plans serving the LTSS population coordinate for HCBS.

Aetna Medicaid manages the following types of LTSS benefits across health plans:

- LTSS (HCBS, assisted living, nursing facility [NF])
- HCBS – consumer directed
- MFP
- Non-emergency transportation Hospice
- Behavioral health
- Physical/acute
- Care coordination for all LTSS members
- Medicaid/Medicare integration – managed LTSS services

How our proposed LTSS program in Iowa will work

Our member-facing care management structure is centered on the needs and preferences of the member and the member's circle of support: family and caregivers; physical, behavioral, and LTSS providers; and the community resources needed by each member. Our innovative outreach and engagement processes support shared decision-making, member choice, and the desires and goals of the member as recorded in the member's Care Plan.

Assessment and reassessment processes identify, clarify, and document the level of care (LOC) and services required for each member. Our processes also consider the dynamic changes occurring in each member's life that must be addressed to meet continually changing needs. We:

- ***Tailor care, services, and treatment to members with unique health care needs*** and circumstances to make it possible for them to help achieve meaningful gains and optimal health
- Emphasize ***one-to-one contact with an assigned, dedicated Case Manager*** who will help simplify navigation of the health care system and help relieve member and caregiver burden
- Seek solutions that offer members and their caregivers ***options for community living*** with the greatest flexibility and adaptability in obtaining services to fit their individualized needs
- Serve our members and families with the ***rapid responsiveness*** of the Aetna Medicaid infrastructure that includes Member Services, 24/7 clinical support, and comprehensive medical management services to help the member and caregiver get what the member needs, when needed
- Assess each member as an individual through ***standardized evidence-based assessment*** tools; use risk assessment tools to offer focused, relevant services for members with special health care needs
- Use Aetna Medicaid's ***sophisticated information systems***
- Create a Care Plan to build a plan of action that is ***unique and tailored*** to the needs of the individual member
- Offer the opportunity to build an individualized Interdisciplinary Care Team for each member in need of LTSS. Through this approach, we link the member with a team chosen specifically for them that integrates medical and behavioral care and coordinates services and supports needed for the member to live successfully in the ***least-restrictive environment***
- Continuously ***assess member experience*** and the need for reassessment any time the member experiences a change in condition, which may require a change in the Care Plan to meet the member's changing needs
- Coordinate and monitor ***continuity of care*** for LTSS members through our care coordination Quality Management processes and our plan-wide Quality Improvement program
- Maximize member choice for those who desire self-direction in the provision of HCBS
- Hire and collaborate with ***locally based, qualified, and experienced Iowa Case Managers*** and other culturally competent staff
- Promote smooth, ***seamless transitions*** from skilled nursing facilities (SNFs) to home care services for LTSS members
- Contract with current LTSS providers and ***enhance the network***, as recommended by members or advocacy groups

Our members obtain their services locally—hence, we use a local, community-based model for ICM, working with community-based Case Managers and deploying Aetna Better Health Case Managers in the communities where they are needed. Our Case Managers are well trained to serve the member population and are knowledgeable about the environment, available providers, and resources in urban

and rural communities. We incorporate community resources in planning and coordination to make reasonable efforts not to duplicate state and community services.

During assessment and care planning for each member, we identify inappropriate or redundant services and eliminate them while adding those that are missing. We act as the integrator of care delivery.

NOTE: Throughout this section, we use the term *Care Plan* to refer to the integrated electronic document that stores the comprehensive assessment results, Care Plan, and services for the members.

Attachment 5 – Section 4.1, Question 1 [SOW 4.1]

1. **Explain how you will ensure that individuals are served in the community of their choice and that funding decisions take into account member choice and community-based resources.**

We provide options to serve Iowans in the community

To meet Iowans where they are and keep them where they want to be, we will implement a person-centered process that identifies the member's community-living goals, see that funding is aligned with their choices and their community resources, and comply with consent decrees. Our care planning process uses motivational interviewing to engage the member in a conversational way to help the member identify goals and priorities for community choices.

PERSON-CENTERED PROCESS IDENTIFIES THE MEMBER'S COMMUNITY-LIVING GOALS

Our person-centered planning process facilitates and encourages the member to exercise their ability to direct goals in their life with the assistance of their support system. ***Member choices drive the Care Plan; the member's use of community-based resources flows from the Care Plan.*** During the planning process, Case Managers help members identify their independent living goals and give them information about local resources that may provide greater self-sufficiency in housing, education, and employment.

To assess the member's readiness for community living, we conduct our health risk-screening and other screens, enabling us to engage them in our population health programs. Our Case Managers continuously monitor and review achievement of member-defined goals.

FUNDING ALIGNED WITH MEMBER CHOICES AND COMMUNITY RESOURCES

Our Nursing Facility Diversion program and collaboration with MFP, will increase the number of members living in the community of their choice. We ***help members understand their options for services*** and the cost implications associated with these choices. We encourage members to live in the least-restrictive settings possible, in accordance with their personal preferences, whether remaining in their own homes or choosing an alternative residential setting instead of an institution.

For members receiving or moving into HCBS and the Consumer Choices Option, we use **a** cost-effectiveness tool. We calculate and share with the members different scenarios of services based on their needs and preferences so their plan aligns with the budget available.

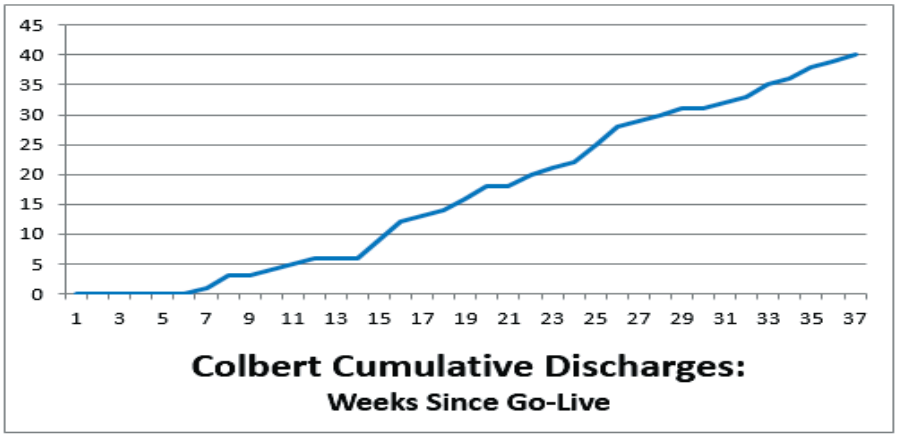
Our oversight of the process provides that the costs of HCBS are not higher than facility costs: If the cost-effectiveness model suggests that HCBS is 85% or more of NF costs, the case is reviewed by Case Management. The member plays a key role in aligning funding, services, and settings through the decisions they make.

COMPLIANCE WITH CONSENT DECREES

In Iowa, we will work closely with the Iowa Olmstead Consumer Taskforce and its community-based members to identify innovative approaches to implementing community-based services and increasing availability of community housing and supports. We have been very successful in working with state Medicaid agencies to implement consent decrees. Our Illinois plan exceeded benchmarks by facilitating discharge and transition to the community of 40 members within the first seven months of our Contract, as shown in Figure 4-2 below.

Illinois – Colbert Consent Decree
Our Illinois plan provides services under the December 2011 Colbert Consent Decree, which was the result of a lawsuit filed in 2007 by the Colbert Class Members. The requirements of the decree include affording people with disabilities a real opportunity to live and participate in their communities, no longer making an SNF the only housing option. The defendants, collectively represented by the Illinois Department of Healthcare and Family Services, contracted with Aetna Medicaid to help the Department comply with the terms of the Colbert Consent Decree and the associated Implementation Plan.
The successful execution required direct communication among all stakeholder organizations to identify and mitigate risks, reconcile disagreements, and clarify mutual expectations and accountabilities. The health plan assumed full responsibility for obtaining the documentation needed to obtain funding for housing for the class members they serve. This work to obtain funding for housing eliminated a major barrier for members transitioning out of nursing homes. As a result of our efforts, we facilitated discharge and transition to the community of 40 members within the first seven months of our Contract.

Figure 4-2: Aetna Better Health of Illinois completed more rapid NF discharges to the community than required by the Colbert Decree Implementation Plan



4.2 Level of Care and Support Assessments

Attachment 5 – Section 4.2, Question 1 [SOW 4.1, 4.2.1, 4.2.2, 4.2.2.1, 4.2.2.2]

1. **Describe your ability and process for conducting level of care reassessments and tracking and determining when a reassessment is required.**

Scope of Program for assessments and reassessments

We propose to use the standardized InterRAI and Supports Intensity Scale tools for our LOC assessments. Our LTSS Case Management staff are experienced in administering the InterRAI Assessment and can fully integrate this tool with our LTSS Care Management program. For example, our New Jersey health plan uses tools from the InterRAI Assessment suite in their LTSS program. We will collaborate with the Agency to evaluate the member's LOC and enroll the member into LTSS. These tools will be integrated in our Care Management Information System to support both LOC and service needs assessment; provide reporting to the Agency; and facilitate development of a Care Plan that is aligned with the member's needs for services and supports to sustain successful living at that level.

We acknowledge that the Agency is responsible for determining the initial LOC assessments for nursing facilities or ICF/ID or for HCBS waiver enrollment for individuals who are not enrolled with us and are applying for Medicaid eligibility. We will coordinate with the Agency to transition that assessment information to us when a member is enrolled in our plan, and will refer inquiries about initial enrollment to the Agency or its designee using the format required by them.

Delaware Physicians Care held numerous public forums and meetings with providers before and after implementation of the MLTSS program. Meetings included long term care providers, Financial Management Services for Self-Directed Attendant Care, Meals on Wheels providers, and personal care agencies.

Within 90 days of the start of operations, Case Managers successfully visited 1,136 of 1, HCBS members, a face-to-face contact rate of 96%. The remaining program members were identified as deceased, hospitalized, or unable to be located by the state and the plan.

The plan collaborated with the state to research and gather information about the members whom we were unable to locate; we then updated the enrollment files.

In the first 19 months of operations, there was an 8.8% reduction in members in institutional settings, showing an effective process of members to the community.

LEVEL-OF-CARE ASSESSMENT

An Aetna Better Health Case Manager will perform assessments. The Case Manager will have attended training and will be certified by the plan to conduct the InterRAI Assessment, HCBS service needs evaluation, and options counseling. To conduct the assessment, the Case Manager will visit the member in his or her home. The Case Manager will complete the InterRAI or other appropriate assessments, provide options counseling, develop appropriate documents, and gain signatures on them. InterRAI Assessment data will be shared with the Agency based on established mechanisms. In developing the Care Plan, the Case Manager will discuss the appropriate Iowa LTSS services. These include Medical Day Care and Personal Care Assistance as determined by the InterRAI and HCBS Needs tool as being needed to support the member's LTSS care needs.

We administer the initial modules of InterRAI during the initial assessment and for member reassessments. These initial modules include assessment of:

- Intake and information
- Cognition
- Communication and vision
- Mood and behavior
- Psychosocial well-being
- Functional status
- Continence
- Disease diagnosis and health conditions
- Skin integrity and conditions
- Nutritional status
- Medications
- Treatment and procedures
- Social supports
- Environmental assessment
- Discharge potential and overall status

We may administer additional InterRAI modules or Aetna assessments, if needed. These include functional assessments, chronic, condition-specific, evidence-based assessments, environmental assessments, medication adherence screening, and specific behavioral screening tools.

Timeframe: We prioritize newly enrolled members in Medicaid based on available information provided by the State. We call the members within five days of enrollment. Combined with data from the Agency, this process will enable us to prioritize and make visits soonest to high-needs members. ***We will complete initial assessments with all members enrolled at startup within 90 days. After 90 days of plan operations, we complete the initial assessment of new members within 15 days of enrollment.***

Members who may need LTSS: Some members may not currently be receiving LTSS but may be eligible. We identify these members through multiple methods. These include, for example:

- Consolidated Outreach and Risk Evaluation (CORE) predictive modeling, which identifies members who may have a changing level of need, including LTSS.
- Care management services for high needs; non-LTSS members may identify members who have a changing LOC need.
- Claims surveillance or prior authorization patterns may indicate a member who has a changing LOC need.
- Referrals for an LTSS assessment from any source who is in close contact with the member. Sources may include the member, the member's physical or mental health provider, automated hospital notifications, or hospital discharge planning.

We will conduct a comprehensive assessment for these members. We will coordinate closely with the Agency to appropriately refer members who may be eligible for LTSS and acknowledge that the Agency or its designee will make the LOC determination, if applicable.

Per Agency requirements, we will develop policies and procedures specifying our tools and processes, including use of member and provider referrals, hospital notifications, and ongoing review of data to identify members for LTSS. We will submit these tools, policies, and procedures to the Agency for review and approval before implementing the program.

ANNUAL SUPPORT ASSESSMENT AND REASSESSMENTS

Our LTSS Case Managers will reassess each member for clinical eligibility annually. They will also reassess members when there is a significant change in a member's functional status or medical/behavioral condition, including cases in which a decline or improvement:

- Will not normally resolve itself without intervention
- Impacts more than one area of the member's health status or requires interdisciplinary review

We will also conduct an InterRAI Assessment prior to the member's discharge from an NF to an HCBS setting. We will conduct the annual redeterminations between 11 and 13 months from the last InterRAI Assessment.

For members who are currently enrolled in managed care and an LTSS plan that are transferred to Aetna Better Health, we prioritize face-to-face contact and subsequent assessments based on the complexity of the members' needs. The existing InterRAI Assessment and prior health plan's Care Plan for the member will continue without interruption for 180 days or until we conduct a new InterRAI Assessment, develop a new Care Plan, and authorize and begin HCBS according to the new plan. We will expedite the assessment and development of the Care Plan for members designated as high-risk, based on the needs of those members. We understand that any proposed LOC changes must be approved by the Agency before implementing the new Care Plan. These approvals (or denials) will be documented in our Case Management Information System and can be accessed by practitioners on the member's Interdisciplinary Care Team.

We will configure our Case Management Information System to incorporate data elements from the Agency-required assessment tools, InterRAI, and Severity Index Scoring assessment. Our systems fully document all elements of the member assessment, including date of the assessment and next scheduled assessment. These elements can be tracked and reported individually by member, by date, or in aggregate as a performance indicator for us.

SUBMITTING TIMELY LOC DOCUMENTATION FOR STATE REVIEW

We acknowledge the requirement in RFP item 14.6.9: Timeliness of needs assessment and reassessments. We will report on completion of needs assessments and reassessments for 1915(c) HCBS waiver members and understand that 100% of needs assessment will be completed within the timeframe mutually agreed upon with the Agency.

MEMBER INELIGIBILITY

We acknowledge that the Agency makes the determination of eligibility for LTSS. If, in the course of an annual or needs-based reassessment, we identify a member who appears not to meet criteria for LTSS, we will inform the member of that finding. We will also inform the member that they have the right to continue the process and we will not discourage the member from doing so. If the member decides to continue or discontinue the assessment, we will complete the necessary documentation and submit it to the Agency within the required timeframe for a final determination.

For members who are seeking community-based services through the HCBS 1915(c) waiver and for whom a slot is not available, we will collaborate with the Agency to keep members on the HCBS waiver waiting list informed about the process; this will allow moving them to HCBS when a slot is available. We will advise the member of options for facility-based services until a waiver slot is available and will work with the member to identify other support that may assist in meeting the member's needs. For LTSS, HCBS wait list, high-needs, and non-LTSS members who need supportive services, we will continue to manage the individual through our ICM program.

Attachment 5 – Section 4.2, Question 2 [SOW 4.2.2.2]

2. Propose the approach by which needs assessments will be administered in a conflict-free manner consistent with BIP requirements.

OUR CONFLICT-FREE CASE MANAGEMENT POLICIES

We understand the Agency's intent to provide conflict-free case management (CFCM) to mitigate conflicts of interest in providing community LTSS by the following:

- Separating the determination of needs and development of the Care Plan from the financing decisions
- Preventing incentives for those who develop the Care Plan to direct services towards certain providers with which they have a relationship

Prior to Contract implementation, we will develop formalized policies and procedures on CFCM for Iowa. Aetna Better Health has two processes to prevent these conflicts of interest.

For Case Managers: We eliminate incentives to reduce or deny community-based services by separating care planning and Utilization Management (UM) functions. The Case Manager develops the Care Plan based on assessment of the member's needs. For members who are enrolled in the Consumer Choices Option, the Case Manager will work with the member to agree upon the scope and frequency of services to be provided. The member can take advantage of a budget authority model if he or she so chooses.

Do the Right Thing
for the Right Reason

This model allows the member to negotiate caregiver wages to be less than the maximum allowable pay. By doing so, the member can expand the scope and frequency of services from the caregiver while staying within the approved budget.

Among Service Providers: We will contract directly with LTSS providers. Our policies, procedures, and contract requirements will prohibit our staff from referring their own family members or to serve as paid caregivers for our members. For members enrolled in the Consumer Choices Option, our support broker and financial management intermediary will have specific contract obligations that:

- Require them to review arrangements for actual or potential conflicts of interest
- Prevent them from referring their own family members to health plan members to serve as paid caregivers of our members
- Prohibit a member's authorized representative from serving as a paid caregiver

Attachment 5 – Section 4.2, Question 3 [SOW 4.2.3, 4.2.2]

3. Propose a timeline in which all assessments shall be completed:

a. Upon initial enrollment with the Bidder
b. When the Bidder becomes aware of a change in the member's circumstances which necessitates a new assessment
c. At least every twelve (12) months

PROPOSED TIMELINE FOR ASSESSMENTS

Using claims and benefit enrollment (ANSI X12-834) data provided by the Agency before initial enrollment, we will prioritize members for assessment outreach. We contact every member with a Welcome Call and brief member risk screen to help this prioritization.

Our proposed timeline is as follows:

- **Initial Assessment:** We will contact all LTSS members within five days of Contract start to identify members with immediate needs, and begin our face-to-face visits immediately. We will conduct the initial assessment of all members within 90 days of enrollment for the initial transition and within 15 days of enrollment for all new members after the first 90 days of the Contract.
- **Reassessment:** We will conduct comprehensive reassessments no less than every 12 months from the last assessment. We will conduct interim reassessments if warranted by changes in the member's status. We review the member's Care Plan monthly with every member in LTSS, and use this opportunity to identify needs and trigger a reassessment if the member's status and needs have changed.

The existing InterRAI Assessment and prior Care Plan for the member will continue without interruption for six months or until we conduct a new InterRAI Assessment, develop a new Care Plan, and authorize and begin HCBS according to the new Care Plan.

Attachment 5 – Section 4.2, Question 4 [SOW 4.2.2.2, 4.2.2.3]

4. Describe your plan to track and report level of care reassessments.

OUR INFORMATION SYSTEM INFORMS AND TRACKS ASSESSMENTS

We use our integrated Case Management Information System to manage all aspects of our LTSS Care Management program. In this system, we capture data on LOC assessments, care planning, and services. The system also flags upcoming tasks such as due dates for LOC reassessments. Through remote access, the Case Manager can make system updates while face to face with the member. The Case Manager can enter the member's answers to assessment questions, verify information, and take immediate action.

We recognize that LOC assessments drive eligibility determinations and that we have a shared responsibility for acting on assessment information with the State. When starting a new Medicaid managed care program, we review 100% of cases to make certain assessments are accurate and that we have met the required turnaround times. We will report on LOC assessments and other characteristics of the LTSS program in the format and frequency required by the Agency.

Additional details of our tracking programs are included in our response to Attachment 5 – Section 4.3, Question 8, and in our response to Section 9: Care Coordination.

Attachment 5 – Section 4.2, Question 5 [SOW 4.2.5, 4.2.3.1.2]

5. Vendors must work with the State or its designee responsible for implementing the PASRR process. Propose strategies to ensure members receive the specialized services and supports indicated by the PASRR level 2 screening.

OUR COMMITMENT TO PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

We will collaborate closely with the Agency or its designee responsible for the pre-admission screening and resident review (PASRR) process. We expect that all members admitted to an SNF will be screened with PASRR I and with PASRR II if indicated. The member's assigned Case Manager will coordinate the PASRRs. We will manage the PASRRs according to the same processes and standards used for members in facilities, including ongoing reassessment for interest in and capability to transition to community-based settings.

The assigned LTSS Case Manager will coordinate and confirm completion of the PASRR Level I screening when a member is identified for potential NF placement. If a level II PASRR evaluation is indicated based on the findings of the Level I, the Care Manager will coordinate with behavioral health resources to conduct the assessment. When a member's Level II PASRR evaluation indicates that he or she cannot be placed in the chosen residential setting, the Care Manager will schedule an Interdisciplinary Care Team (ICT) meeting to discuss the member's special needs and service options and develop an alternative plan for placement. The ICT will discuss reasons why the preferred placement is not possible; identify at least two other available facility or community-based residential options; and facilitate the placement selection by the member or his or her legal representative.

Members who are subsequently admitted to a skilled NF, ICF/ID, or acute-care setting will be regularly re-evaluated by their assigned LTSS Case Manager using our SNF concurrent review process. Our Case Managers will coordinate care with the facility and will regularly assess the member's readiness to return to their community. We will work with the Agency to safeguard that members being admitted for institutional services are appropriately screened and evaluated for support services in the community.

We will authorize admissions to NFs and ICF/IDs with which we have a good standing. If a member cannot get an institutional bed, we will support him or her in the community until she or he can be moved to the appropriate LOC. For example, our Case Manager might arrange for a personal attendant or medical day care to meet the member's needs while they are on the wait list. We will get authorization for facility admissions when required and understand that in circumstances we can authorize our own transfers to the community.

4.3 Community-Based Case Management Requirements

Attachment 5 – Section 4.3, Question 1[SOW 4.4.6, 4.3.6]

1. Describe your proposed model for delivering LTSS care coordination services.

Integrated Care Management for LTSS

Pioneer in Fully Integrated Care Aetna Better Health will implement an integrated program for LTSS for all members enrolled in managed LTSS, including those in HCBS and the Consumer Choices Option. Our model coordinates all services and:

- Values the LTSS members whom we serve, putting our members at the center of our support with special respect for their ***rights of privacy and self-determination*** and support for their individuality, dignity, and independence
- Provides information and guidance to assist the member/family in making ***informed decisions*** and implementing supports identified in response to InterRAI assessments
- Provides a ***continuum of service option*** that supports the expectations and agreements established through the care planning process
- ***Educates the member and family*** on how to report problems with service delivery or availability
- ***Facilitates access to non-medical and natural support*** services available throughout the community
- ***Advocates for the member***, family, and significant others as needs occur
- Provides ***flexible and creative*** service delivery options
- Assists members in identifying their ***independent living goals*** and provides them with information about local resources that may allow them greater self-sufficiency in the areas of housing, education, and employment

- Is dedicated to ***providing high-quality health care services*****,** including appropriate health screening and disease prevention to our members
- Is committed to ***sustainable long-term partnerships*** with our provider network to facilitate provision of the most effective and efficient services to members
- Forges ***partnerships with community agencies and stakeholders*** who work with vulnerable member populations for individual and community empowerment
- Promotes ***health, wellness, and quality of life*** for members in the community and in ICF/IDs and nursing facilities
- Strives to ***be the managed health care plan of choice*** for families and those with special needs
- Supports ***community initiatives*** designed to improve the health of all members
- Supports ***continuity for members*** already receiving LTSS until a person-centered reassessment is completed.
- Arranges a ***coordinated transition*** for members transitioning into LTSS with no disruption in health care or service delivery
- Is committed to ***financial stability*** to secure the viability of our mission

Our LTSS Care Management will drive quality-based outcomes that include the following:

- Improved/maintained functional status
- Improved/maintained clinical status
- Enhanced quality of life, member satisfaction, and adherence to the Care Plan
- Improved member safety, cost savings, and member autonomy

Aetna Medicaid's approach to LTSS Care Management is member-focused rather than disease- or problem-focused. We support the concept that ***members have a right to determine what is best for them.*** Our role is to assist them in understanding and facilitating InterRAI assessments and the services specified by the findings. We incorporate members' values, needs, and priorities using a culturally sensitive approach. We ***capitalize on each member's strengths*** and supports and use motivational interviewing techniques to enhance communication and member engagement. ICM manages the continuum of member care needs by providing a range of care from acute and solution-focused interventions to complex care management, LTSS, and end-of-life assistance, always aiming to keep members in the most integrated and least-restrictive care environment possible.

At every step, we encourage autonomy and active self-management of acute and chronic conditions where clinically appropriate. To support the member in this journey, we provide tools and education directed at his or her unique needs. A well-trained Aetna Better Health community-based Case Manager serves as the single point of contact for the member. ***We collaborate with the member, the members' supports, and the ICT to create a Care Plan that includes mutually agreed-upon member-centered goals and actions*****.** The Case Manager and the ICT coordinate both covered and non-covered services. We collaborate with members, their families, community supports, community Case Managers, providers, and practitioners to enhance care outcomes. We encourage all members to follow age-appropriate screening and health-maintenance guidelines as well as evidence-based care for chronic physical and behavioral illnesses. Every assessment and encounter includes attention to comorbidities and to reducing unhealthy behaviors (such as tobacco use or substance use disorders) in a member-centered manner.

ICTs are a key feature of our program. All LTSS members are invited to participate in ICT meetings, with participants chosen by them. ICT meetings can be instrumental in efforts to manage challenging behaviors, frequent ED visits, or hospitalizations or other complex cases including those that exceed the cost threshold for HCBS or create significant risk for HCBS placement.

The ICTs always include the member and Case Manager, Case Manager Supervisor, LTSS member representative, and behavioral health administrator and may also include a medical director, behavioral health medical director, clinical pharmacist, concurrent review manager, RN nurse manager, RN nurse supervisor, or other providers or Department of Health Services (DHS) representatives who may assist in the member care.

The team discusses issues such as how to reduce the frequency of hospital admissions for members with multiple admissions or strategies for maintaining the member safely in the most integrated setting.

OUR CARE COORDINATION PROCESS

Before Aetna Better Health "goes live" with LTSS members, we will prioritize members for stratification levels, based on past claims information provided by the Agency, an existing Care Plan, and outreach by telephone to the member or their representatives. Once we obtain this information, the clinician who triages the case will assign the member to an initial service coordination level.

- We first review the enrollment file, including the member name, contact information, and any special needs or waiver indicators included on the benefits enrollment ANSI X12-834 file into our care management application.
- Our outreach team calls members within specified time limits and administers an initial questionnaire to facilitate triage and prioritize subsequent outreach. As we are trying to reach the member by telephone, we contact all known providers, schools, and community service agencies. If we cannot reach the member by telephone after three attempts and cannot contact them by other means, we send a letter to the member's last known address with instructions to contact us.
- Based on the results of the initial questions, we provisionally assign the member to intensive or supportive care management. We assign intensity of ICM services after assessments, based on the member's needs and level of stability. Table 4-1 shows these levels.
- Our community-based Case Manager conducts a comprehensive needs assessment using tools including InterRAI assessments, behavioral health assessments, and other assessment tools as indicated by the member's conditions.
- The Case Manager and Care Team consider assessment results, the member's identified goals, biopsychosocial barriers, and supporting strengths and uses this information to collaboratively formulate the Care Plan.
- We follow up on activities and monitor the member with face-to-face visits, at the minimum frequency required by the State or at a greater frequency based on the member's needs.

Table 4-1: Criteria for Aetna Better Health ICM for LTSS

Intensive	Supportive
Intensive – Require knowledge and skills of a Clinical Case Manager (for example, RN, LCSW) • May be experiencing immediate care needs • May have numerous unstable medical conditions • Risk for institutionalization • Severe psychosocial health conditions • Are at-risk for an adverse event • May have complex care needs that require more frequent interactions with member, caregiver, or Care Team so needs can be adequately met • May have disruptive behaviors that pose a danger to self or others • Can be transitioned to a lower level of service once clinical needs have been stabilized	Supportive – The majority of LTSS members fall into this category. • Have chronic health issues or may have functional decline • Receiving private-duty nursing or personal care services • Receiving HCBS • Substance use • Do not require intensive level of frequent contacts to maintain them safely in their current setting • Are assigned to a Case Management Coordinator who assists the member or family in identifying and coordinating resources to meet member-specific needs • Clinical consultation and support may be solicited when clinical needs arise

Once a Care Plan is in place, we do the following:

- We arrange for or provide oversight of all services and supports needed by the member to successfully live in the most appropriate setting.
- We monitor members across biopsychosocial domains to proactively prevent crises or institutionalizations and to promote healthy living.
- Our information systems capture information that enables Case Managers to monitor changes in member status, gaps in care, and member experience. We use claims surveillance, ED visits, inpatient information, and care planning tools shared with community providers.
- We monitor our own performance against goals established for interacting with members, providers, community-based organizations, and the Agency.

Once the LTSS Care Management program is in place, the Case Manager assesses member status at each contact. This status includes transitions such as discharge from an acute-care setting; changes in physical or behavioral health status; changes in family, school, or work status; or changes in primary care providers (PCP) or specialists. Assessments may change the member's service coordination level and drive modifications to the Care Plan to better address needs. If the reassessment shows that we need to monitor the member more closely, we may assign the individual to a higher LOC management. Conversely, if the assessment process identifies that the member needs less oversight, we may move the member to a less intensive level of service coordination.

The member, representative, or any member of the Member Services team can ask for a reassessment based on the member's condition, change in circumstances, or any other reason. If we receive a request, we will complete the reassessment within seven days of the request. The member or representative and Care Team will be involved in the decision to adjust the service coordination level, if needed. The Case Manager updates the Care Plan and reviews any changes with the member for agreement before finalizing the new plan. We inform members of their right to dispute any changes; if they choose to dispute the change, the Case Manager will assist them through the process.

VISIT FREQUENCY AND CONTENT

Prior to contract implementation, we will work with the Agency to confirm that our procedures comply with Agency requirements and Iowa Administrative Code. Our proposed level of contact for each service level is as follows.

- Intensive – At least four face-to-face meetings each year and monthly contacts by telephone (includes all HCBS)
- Supportive – At least two face-to-face meetings and six contacts by telephone each year

Our policy and procedure for in-person visits will require the Case Manager to:

- Conduct an assessment based on program level and LOC eligibility requirements
- Document the following:
  - Member's physical condition including observations of the member's skin, weight changes, and any visible injuries
  - Member's physical environment
  - Member's satisfaction with services and care
  - Member's upcoming appointments
  - Member's mood and emotional well-being
  - Member's falls and any resulting injuries
- Develop or review the back-up plan (also called emergency or contingency plan)
- Offer self-directed care if HCBS
- Establish that additional waiver-specific requirements have been met
- Document the member's concerns or questions
- Document concerns or questions from the member's representative or caregiver (when the representative or caregiver is available)

Our Case Manager will contact each HCBS waiver member at least monthly in person or by telephone, maintaining an interval of at least 14 calendar days between contacts. The Case Manager will visit the member in their residence at least quarterly, with an interval of at least 60 days between visits.

If the member's condition requires an additional face-to-face visit and a comprehensive Care Plan update is completed, the next quarterly assessment will be completed within 60 days of that assessment and Care Plan update.

WE WILL USE ENHANCED COMMUNICATION AND CONTACT WITH MEMBERS

We will use multiple methods to communicate with and educate Iowa's LTSS members. Our dedicated LTSS Care Team will direct the member to resources that provide information, support the member's communication needs, and help engage the member in his or her care. We know that many of our members are knowledgeable and comfortable with using the Internet and smartphones. We identify how each member wants to communicate; then we communicate with them based on their preferences: e-mail, postal mail, calls, and so on. Our communications resources for LTSS members include:

Member website. The member website helps members get information when and where they need it. It is compatible with Section 508 of the Americans with Disabilities Act. It is optimized for use with mobile devices such as smartphones or tablets. It includes provider search tools, the Member Handbook,

descriptions of covered services and benefits, information on how to file complaints and appeals, links to community resources, information on Case Management, and instructions explaining how to contact Aetna Better Health. The website has a tab that is specifically for LTSS members. This tab contains links to the community-based services that support LTSS.

Aetna Better Health App. Every member deserves to have the right information to make good decisions. To support this right, we will offer the free Aetna Better Health app for both iOS and Android smartphones. The app will have several functions to make it easier for members to find information and coordinate their health care needs.

Language access. Language and communication barriers can hamper effective engagement of the member in their health care. We provide the right tools and services to facilitate member communication—not just with customer service, but with providers at the point of care. To address these and other communication issues, we offer language assistance services that include:

- Face-to-face and video interpretive services during medical and behavioral health appointments
- Access to certified telephone interpretation services for more than 200 languages using language services
- Relay services that provide full telephone accessibility to people who are deaf, hard of hearing, deaf-blind, or speech disabled
- Special assistance for cognitively impaired members or their caregivers, as needed

Culturally targeted services. We address each member's cultural, spiritual, ethnic, and linguistic identification preferences. These preferences are included in the member's Care Plan and drive provider and service choices. Our materials reflect a variety of language and communication approaches and are written in simple language so that members can understand.

Mobile telephones for safety and health messaging. We will evaluate options for helping members access telephone and web services through public programs and use these tools for health messaging. Aetna Medicaid has partnered with SafeLink Wireless and Voxiva to offer free mobile telephones and health messages to Medicaid members. We project that the mobile telephones will contribute to member and representative feelings of safety with their community services.

Attachment 5 – Section 4.3, Question 2 [SOW 4.3.1]

2. Propose the required qualifications, experience and training requirements for community-based Case Managers.

Our Case Managers have experience and create member relationships

Committed to Health Care Transformation in Iowa

Aetna Better Health Case Managers will be licensed registered nurses, licensed behavioral health professionals, and individuals who are either degreed in the Human Services or related fields with LTSS Care Management experience. ***The role of the Case Manager is to collaborate with members or families in assessing, educating, facilitating, planning, advocating, and addressing the member's individual needs.*** Their role may vary depending on caseload setting, cultural needs, economic situations, and member's individual needs. Case Managers do not provide direct care services to members; instead, they assess, reassess, and authorize appropriate services and refer members to services.

Case Managers will have specific expertise working with specific LTSS and HCBS waiver populations; they must also be able to:

- Assess the member's medical, functional, and social needs:
  - Identify the member's medical, cultural, and psychosocial needs
  - Review medical information and past history
  - Assess environmental factors
  - Identify any services that the member is currently receiving (covered and non-covered)
  - Work with the member and his/her support systems
  - Discuss participant-directed care options
  - Solicit information from the member's PCP or other service providers
- Develop individualized Care Plans
  - Collaborate with member and family to develop a Care Plan that enhances outcomes and promotes independence
  - Verify that member and family agree with and sign off on Care Plans
  - Build on the strengths that member and family possess based on unmet needs, personal goals, and risk factors
  - Include both formal and informal services in each Care Plan
  - Assess the cost-effectiveness of the services within the plan
  - Arrange for services to supplement basic care performed by a facility or alternative residential setting
  - Make arrangements so that members are maintained in the most integrated and least-restrictive setting, considering member preferences and safety
  - Obtain member signature and date on plan and document member's agreement/disagreement with Care Plan and options counseling in electronic case record
- Implement, facilitate, and coordinate services:
  - Coordinate the Care Plan with member and family
  - Coordinate medical services with the member's health care provider(s)
  - Use cost management strategies and act as gatekeeper where necessary, while seeing that quality care and services are delivered to the member
  - Develop appropriate contingency and back-up plans for non-provision of services for HCBS members
  - Discuss potential patient pay responsibility for NF placements or room and board payments for assisted living placements
  - Meet required timeframes for service initiation and follow-up
- Monitor, evaluate, and modify services and outcomes:
  - Verify that services are provided as authorized
  - Review plans for continuity of care and progress toward expected outcomes
  - Identify risk management issues and develop appropriate plans
  - Obtain member's signature every time there is a change in the Care Plan
  - Provide appeal rights any time there is a change in the services authorized, and facilitate the appeals process

- Provide conflict-free care management services (see our response to Section 4.2, Question 2)

ESSENTIAL BACKGROUND FOR CASE MANAGERS

Our Case Managers must have at least one year of work experience with the elderly or physically disabled in an institutional or community setting. We also look for knowledge or experience in interviewing and assessing members, caseload management and casework practices, and experience or training in LTSS Care Management techniques for special subpopulations. We look for understanding of human service principles for determining eligibility for benefits and services and the ability to solve problems effectively and locate community resources. We expect new hires to be familiar with the general needs and service delivery system for our LTSS members.

OUR PLAN TO RECRUIT IOWA CASE MANAGERS

Local Based Plan We will recruit qualified community-based Case Managers in Iowa who may already have relationships with the member population and the organizations providing services to members. We will look for experience with our member populations, knowledge of the community, and the skills required to offer person-centered, integrated care to our members. Some organizations we will talk to include the Iowa Nurses Association, Iowa Board of Nursing, Iowa Organization of Nurse Leaders , and job boards.

COMMUNITY-BASED CASE MANAGER TRAINING

Our training for LTSS Case Managers is multidimensional, incorporating LTSS Care Management, Family and Community Collaboration, and ongoing training. The assigned community-based case manager for members who choose to self-direct services, as described in Section 4.4.8, will have specific experience with self-direction and additional training regarding self-direction. We describe these below.

LTSS Care Management Orientation and Training: All new Case Managers complete an online orientation covering benefits and a review of various standard Aetna policies. This includes information on the mission, values, goals, code of conduct, and other staff requirements. New staff must take the general set of Iowa health plan training, which includes Introduction to the DHS, Introduction to CMS, Business Continuity, Emergency Preparedness, and Identification of Quality of Care Issues/Critical Incidents.

LTSS-specific orientation and training is required for all new Case Managers; the Learning and Performance Department is responsible for this training. All LTSS Case Managers will be certified by the plan to perform assessments using the InterRAI Assessment System and to counsel members on options for care and services.

We have internal tools to track adherence with LTSS Care Management training and certification requirements. Registered Nurses in the LTSS department will be trained to conduct the personal care assistant assessment tool. Prior to the start of new hire training, whenever it is possible, new staff shadow existing Case Managers and visit each type of Case Management role. During this in-the-field shadowing, new Case Managers are mentored by experienced Case Managers, which serves as valuable on-the-job training.

Case Managers receive classroom instruction, observation, and mentoring before they are assigned a caseload. The materials for each training, while standardized to include all relative elements, are updated with the current information and procedures before each training session. The Case Manager training includes:

- Role of the Case Manager in a person-centered approach to LTSS Care Management, including how to involve the member and the member's family in decision-making and care planning
- Motivational Interviewing techniques and applications
- Principles of most integrated, least-restrictive setting for member placement
- Member Rights and Responsibilities
- Care management responsibilities including care planning, back-up plans, reporting service gaps, and notice of actions
- An overview of the LTSS benefits structure
- The LTSS service continuum including available service settings and service restrictions and limitations
- An overview of the provider network by location, service type, and capacity
- Community resources for non-LTSS covered services
- Information on local resources for housing, education, and employment services
- Responsibilities for monitoring and reporting quality of care concerns, critical incidents, and suspected fraud, waste, abuse, neglect, or exploitation
- General medical information, such as symptoms, medications, and treatments for diseases common to LTSS members
- General social service information, such as family dynamics, care contracting, and dealing with difficult people
- Behavioral health information, including identification of member's behavioral health needs, benefits, accessing services within our network, collaborating with PCPs and behavioral health professionals, and requirements for communicating with the member's PCP and behavioral health providers at least quarterly
- Level I and Level II PASRR processes
- Early and Periodic Screening, Diagnosis, and Treatment for LTSS under age 21
- Techniques for managing special needs populations
- Federal and state rules and regulations as they apply to Human Services programs
- Nursing facility or Skilled nursing facility share of cost
- Assisted Living member payment liability
- Participant self-direction service delivery model
- Information systems and tools necessary to manage the Case Manager's case load
- QNXT™ for authorizations
- Care Management Information System for LTSS member management
- Aetna Better Health policies and procedures

Training on Family and Community Collaboration: Training will also include how to collaborate with the following external sources, including:

- Adult protective services
- Accredited training agencies
- Area Agencies on Aging; Aging and Disability Resource Centers
- Consumer advocacy groups
- County-based Emergency Preparedness coordination
- PACE organizations
- Providers (for example, medical or behavioral health)
- Public Guardians
- Local police departments
- LTSS advocacy groups
- Ombudsman for Institutionalized Elderly

- Department of Human Services
- Bureau of Guardianship Services
- Cultural competency

The LTSS policies and desktop procedures are in electronic, online format. These policies and procedures are available to all staff on our intranet LTSS Directory. With the electronic format, we can quickly make even small changes to the document and notify staff of the change via e-mail without the cost and time involved in paper document distribution. We also offer and train staff on our online directory of LTSS services and culturally specific member materials and services, which are accessible to Case Managers in the field.

Refresher and ongoing training: The Learning and Performance Department continually identifies additional training to assist LTSS Care Management staff in enhancing their performance. The Department provides a variety of training opportunities for our staff to enhance their skills. Case Managers must also take annual required trainings, including Cultural Competency; Medicare Compliance; Business Conduct and Integrity; Medicare & Medicaid Fraud, Waste, and Abuse; and State Medicaid requirements such as compliance with quality indicators or performance measures such as vaccine administration and advance directives.

We offer these courses through technology-based training, which can be taken at any time by the Case Manager. Whenever we identify that a Case Manager could benefit from refresher training, as indicated through case record audits, reporting measures, or any other internal monitoring processes, we will make refresher training available.

ACCREDITATION OF CASE MANAGEMENT SERVICES

Our LTSS ICM program complies with NCQA accreditation requirements. Aetna Better Health will seek NCQA accreditation. Our network contracting and credentialing process will safeguard that any contracted providers and community-based Case Managers meet requirements of deemed entities, including NCQA, JCAHO, CARF, The Council, and the Council on Aging. We will work with the Agency to meet applicable Agency and State requirements for community-based Case Management.

Attachment 5 – Section 4.3, Question 3

3. Describe your proposed staffing ratio for community-based case managers to members.

Our proposed staffing ratios for community-based Case Management services vary with the intensity needed to support different levels of LTSS members successfully in the setting of their choice. Our proposed intensity-based caseloads align with our Aetna Medicaid ICM model for staffing. As we assess and develop a more complete understanding of the needs of Iowa members, we will modify the ratios as needed.

We group members according to the intensity of need and assign Case Managers to the number of cases they can effectively support. We assign members with complex needs to Case Managers with the appropriate expertise and experience to manage these members. For members with very complex needs, the caseloads will generally be lower than standard caseloads. Such needs might include, for example, persons with head injury who present with complex behavioral management needs or persons who are ventilator-dependent and residing at home. Our proposed caseloads are listed in Table 4-2.

Table 4-2: Aetna Better Health LTSS Case Manager caseloads and case weights

Population	Maximum caseload per Case Manager	Case weight for each member
Members living in nursing facilities	120	1
Members receiving HCBS (living in their own home or assisted living facility) not receiving self-directed attendant care services	60	2
Members at Intensive ICM program level	35	4
Members in Supportive ICM program level residing in community-based setting	35	4
Members in Supportive program level residing in special care nursing facilities (including pediatric, brain injured, mental health, MR/ID)	60	2
Members living in nursing facilities (nonspecialty)	120	1

We will assign one LTSS Clinical Supervisor to every 12 Case Managers and one non-clinical Case Management support staff to every 12 Case Managers for the Aetna Better Health LTSS Care Management program.

Monthly, we run a case weight report that is based on the Case Managers' assignment data, which is stored in our Case Management Information System. This report is reviewed at weekly Care Coordination Management meetings. The review checks caseload distribution between teams to maximize available LTSS Care Management staff; management adjusts the caseload or Case Manager assignments as necessary.

Attachment 5 – Section 4.3, Question 4 [SOW 4.3.2]

4. Describe how care coordination services will include ongoing communications with community and natural supports.

Communication with Community and Natural Supports [4.3.2]

Pioneer in Fully Integrated Care

Community organizations and other sources of support are essential in providing holistic care for the member. Our biopsychosocial approach to member care coordination means that we ***work to integrate and coordinate services and supports from PCP specialists; community-based organizations offering health, social services, and behavioral services; and other programs that can assist the member***, such as housing, food stamps, or WIC.

Our Case Management Information System helps us to ***track contacts with community and natural supports,*** including targeted Case Managers who serve our members in specific care management areas. ICT meetings promote communications across disciplines and services. Our Iowa-specific LTSS library of providers and services will enable our community-based Case Managers to identify services that may contribute to the member's Care Plan. Our comprehensive Care Plan documents services and care providers connected to the member, which helps us identify and prevent duplication of services***. We also use monitoring and authorizations to prevent duplication and promote efficient service delivery.***

We encourage providers and other community resources who may be serving the member to share information and to become involved in the development and implementation of the Care Plan. By communicating with these individuals and agencies, we facilitate effective coordination of services and supports for the member and enhance continuity of care. These individuals and agencies help sustain the member's engagement with the Care Plan and can alert us when the plan may need to be modified.

Aetna community collaborations that work

Our Illinois plan has developed beneficial partnerships to better serve LTSS members. by working closely with Illinois Health and Disability Advocates (HDA). From the beginning of the Illinois managed care LTSS program, HDA has been onsite at the health plan providing state and population-specific training. This in-depth training has been instrumental in assisting the plan in keeping abreast of state laws, regulations, and socioeconomic and cultural sensitivities to better serve their recipients. This relationship continues today, with regular communication and periodic training.

Our network contracting team will be responsible for recruiting and contracting with providers that serve LTSS members. They will be responsible for implementing Contract requirements regarding notifications for admissions, ED visits, and other transitions of care.

Our community-based Case Managers will work with PCPs, specialists, and clinics regarding the care of our members. Case Managers use these relationships and opportunities to interface with providers to encourage them to contact us with information on changes in member status.

We proactively keep providers abreast of care and care planning processes that we are arranging for our members as well as other relevant topics, including any changes to a member's circumstances or community-based program changes.

Our work with Community Organizations [SOW 4.3.2]

Local Based Plan

Members often have pre-existing relationships with local organizations; such organizations offer supports for members that help their ability to reside in the community. In Iowa, we will develop effective working relationships with community organizations that will help us to understand communities and use community resources most effectively. We work to incorporate community-based resources and non-covered services into the care planning process. We will communicate with these organizations by developing direct relationships and making ourselves available to communicate with them about any member-specific needs.

We have successfully developed these relationships in other states where we offer LTSS services. We work with advocacy, cultural, faith-based, and county-operated organizations that offer key services and information to our members. We communicate this resource information to community-based Case

Managers and providers so that they can collaborate with us in offering referrals to members. The many local, state, and national resources to which we refer members include regional area agencies on aging such as:

- LifeLong Links (LLL) – Aging and Disability Resource Center (ADRC) No Wrong Door program
- Department of Mental Health Services
- A 911 registry (if available)
- Food pantry programs
- Utility assistance programs
- Federal emergency assistance programs

Methods for communicating with the community: We will maintain ongoing communications with community support organizations through the following methods:

- Case Manager placement in community-based settings such as FQHCs, patient-centered medical homes (PCMH) sites, and health homes
- Member Advisory Committee for Iowa
- Aetna Better Health website
- Newsletters
- Community activities: job fairs, health fairs, events

Methods for communicating with providers:

- PCP, health home, and integrated health home contacts
- Fax, telephone, mail, e-mail, provider manual, and Aetna Better Health web portal
- ICT meetings
- Joint meetings with the provider, member, and Case Manager
- Medicity (our provider engagement tool)

Supporting member transitions to other contractors

The Case Manager will obtain information from the member, caregiver, family, PCP, and other providers and resources about services that will require coordination during the transition. The Case Manager will inform providers of the member's transition and the providers' obligations in maintaining continuity of care.

These obligations might include, for example, continuing medication, follow-up surgery appointments, maternity care, requesting and transmitting records, and obtaining prior authorizations as necessary for the receiving health plan. The Case Manager will notify the receiving health plan about the transitioning member's health care needs and facilitate the transfer of pertinent medical records.

Attachment 5 – Section 4.3, Question 5 [SOW 4.3.3]

5. Describe how internal operations support communication among departments to ensure community-based case managers are aware of issues related to their assigned membership.

Internal communication

Our information systems promote sharing of information, but it is the people who work with the member who truly make the system work. We have ***processes to feed data systematically into our Case Management Information System***, including:

- ICT meetings

- Case rounds
- Interdepartmental team meetings (with providers and other caregivers)
- Visits to Health Homes and Integrated Health Homes
- Face-to-face meetings with the member
- ICM Steering Committees
- Care Management Department meetings

Common Platforms for Internal operations: We operate technology tools that capture and integrate information on member outcomes and the effect of care coordination. These systems include our Case Management Information System, QNXT™, and the Actuarial Services Database (ASDB) data warehouse. We also interface electronically with providers through our Aetna Better Health Provider web portal and other approaches. Other elements of our information management systems, such as the member web portal, contribute to our integrated information management and monitoring capability.

Attachment 5 – Section 4.3, Question 6 [SOW 4.3.4]

6. Describe strategies to minimize community-based case manager changes and processes to transition care when a member has a change in community-based case managers.

Continuity of relationships, continuity of care

Transition can be difficult for our members. Our goal is to enable members to preserve Case Management relationships that are working beyond the contractually required transition period. We propose a plan that will minimize the need for Case Manager transition.

We will hire community-based Case Managers, develop positive working relationships with community-based organizations, and bring community-based provider organizations into our network so we can more effectively coordinate care and support their information management needs. Prior to Contract implementation, we will develop comprehensive policies and procedures for Case Manager transitions and will submit them for Agency approval.

OUR PLAN FOR WORKING WITH COMMUNITY-BASED CASE MANAGERS

As we develop our Iowa network and LTSS Care Management program, we will adopt multiple strategies for community-based Case Management. Our approach will improve coordination of behavioral and physical health care and reduce duplication of efforts within the member's system of care. This approach will include the following:

- **Hire community-based case managers** and locate them in community settings, including patient-center medical homes (PCMH); Health Homes (HH); and Integrated Health Homes (IHH) agencies or organizations.
- **Delegate community-based Case Management** to organizations currently providing the service, such as the Area Agency on Aging and Accountable Care Organizations, but provide wraparound services so the member has integrated LTSS and behavioral health services. Delegated agreements will be subject to NCQA requirements for oversight.
- **Contract for specific services** provided by community-based organizations while our Case Managers serve as the primary Case Management provider.
- **Use single-case agreements** (SCAs) as needed to contract for services from a non-network, community-based organization or Case Manager.

We will seek to preserve each member's relationship with the individuals and organizations that are important to him or her. We will continue to work with existing community-based Case Managers as required by the Agency for a smooth and seamless transition to the member. For the remainder of this proposal we discuss how we implement community-based Case Management using our ICM staff; we will fully integrate all community-based Case Management activities under our protocols and processes.

Case Management Transitions at Contract Start: We will make reasonable efforts for members to retain their current targeted Case Manager or community-based case manager (CBCM) for six months after our LTSS implementation. Our goal is to preserve many of these relationships by hiring CBCMs. We will:

- Develop policies and procedures to guide the transitions, and will develop a timeframe for notifying members of any planned changes. Our policies will also address member-initiated and Aetna Better Health-initiated changes in Case Managers
- Educate members on our transition processes. We will make information on Case Management transitions available in our Member Handbook, on our website, and from Member Services staff
- Develop a plan for any transitions from the member's prior Case Managers to our ICM Case Manager if necessary; these plans will be complete within 90 days of the Contract start date. We will complete any planned transitions by a year from the Contract start date
- Recruit organizations providing community-based Case Management services to our network and train them on our policies and procedures for delivering targeted Case Management services for LTSS members
- Adopt best practices for transitions when a change cannot be avoided, such as overlapping Case Managers; will include seamless handoff of all information and planning documents
- Include targeted Case Managers on our ICTs
- Notify members transitioning to a new CBCM that they can appeal the change through our grievance and appeal process, and that we will support the member in filing an appeal
- Our Case Managers will be the points of contact for all stakeholders during the transition process. If a member is transitioning into our plan and the member's provider is not in our network, we will pursue a provider contract or an SCA with the provider to maintain continuity of care and to expand the network, where possible.

If a member, member's family, or caregiver wants the member to remain with a particular provider, we will work with the provider to develop a long-term agreement. Our Member Handbook will explain how to access an out-of-network provider for medically necessary covered services and will also provide continuity-of-care information for new members.

Listen, Respect, and Act with Insight, Understanding, Compassion

Transitions Related To Changes in LOC: Transitioning to managed LTSS or to a different LOC may require a change in Case Manager (for example, a member transitioning from an NF with a dedicated Case Manager to HCBS may have a different Aetna Case Manager). If that happens, we provide smooth handoffs between individual Case Managers. We transition the member's Care Plan and services for continuity.

The receiving Aetna Better Health LTSS Case Manager will meet with the original Case Manager to coordinate services and provide a smooth handoff. Our web-enabled care management technology allows the new Case Manager to identify relevant information about the member and to pick up the Care Plan and oversight requirements. The Case Managers may overlap responsibility for a short period if doing so will help promote a smooth transition.

WE STRIVE TO CREATE CASE MANAGEMENT RELATIONSHIPS THAT LAST

After the initial transition period in Iowa, we will implement processes to ***match the right Case Manager with each individual.*** We will assign LTSS members to LTSS Case Managers based on an assessment of the Case Manager's expertise and the member's need. Our matching criteria include member risk level, geographic location, service setting, and whether or not the member has certain conditions, such as HIV/AIDS, or if the member is enrolled in the Consumer Choices Options.

We assign current members who are transitioning from HCBS to a nursing or assisted living facility to the Case Manager who serves that facility. However, if there was an extenuating circumstance that would require a Case Manager with particular expertise, then that circumstance will dictate the assignment.

OUR POLICIES ON CASE MANAGER TRANSITIONS

We ***consider the member's best interests when making any changes to the Case Manager assignment***; we do not make changes for trivial reasons, nor solely for the convenience of our LTSS Case Management staff.

Transitions initiated by the member: Our LTSS Member Handbook includes information on how a member can request a change of Case Manager. The Case Manager reviews this handbook with the member during the initial visit. The Aetna Better Health Welcome Packet will also contain a flyer reminding the member how they can change their assigned Case Manager.

Members or their representatives can call Member Services to request a new Case Manager or can call the LTSS Case Management Team to discuss their concerns. When we make a change, the newly assigned Case Manager contacts the member within two business days.

Transitions initiated by Aetna Better Health: We make many efforts to avoid having to change Case Managers without the member's request. Our process begins with making the right assignment the first time. Supervisors review our Case Manager case load report and assign members to Case Managers based on member risk level, location, and the Case Manager's expertise and caseload. We examine these factors carefully to make assignments that endure throughout each member's involvement with the LTSS program. This process helps us minimize potentially disruptive changes in assignments.

Attachment 5 – Section 4.3, Question 7 [SOW 4.3.5]

7. Describe your proposed discharge planning process.

Our discharge planning process begins on admission

Our UM program serves as an early warning system for a member's admission to any level of facility. When we learn about a member's inpatient admission, our Concurrent Review Nurses notify our LTSS Department. Our Case Managers review the Inpatient Census report daily. If our Case Management staff receives notification of the admission from the member's family, caregiver, or HCBS provider, the staff member who receives the information notifies our Concurrent Review Nurses immediately. We notify the targeted Case Manager (if there is one) to make certain there is no duplication of efforts.

Our Arizona Managed plan successfully increased seven-day follow-up after a psychiatric inpatient discharge from 33.80% in 2011 to 58.39% in 2013.

Aetna Better Health Case Managers are experienced in planning transitions from inpatient stays in hospital, psychiatric, or detoxification facilities. When a Case Manager sees an admission for an assigned member, he or she:

- Contacts the hospital Case Manager to review the member's condition and begin the discussion about services necessary for discharge
- Notifies any HCBS providers of the member's admission status and asks that they suspend their services
- Contacts the member's PCP to provide notification of the admission and discuss potential changes to the member's Care Plan
- Contacts social work if the member may be difficult to place or eligible to return to the community due to the intensity of the member's need or the time required to place the member
- Coordinates with the facility or CBCM to develop a discharge plan
- Revise the member's Care Plan (pending member and family or caregiver approval)
- Finds an appropriate facility or community setting for the member if needed

Restarting community service: Before discharge, the Case Manager contacts the member's HCBS providers and informs them of the anticipated date of discharge and, if appropriate, directs them to resume previous services. If necessary, the Case Manager and provider will discuss any need to adjust service authorizations based on the member's needs as noted in the revised Care Plan.

Follow-up: We initiate follow-up contact with members discharged from settings within 72 hours. This contact could be by telephone or in person. Our follow-up plans at that point depend on the member's need, the reasons for admissions, and the type of discharge. For example, a member discharged to a stable living situation with satisfactory family support may not get an in-person visit, but a member discharged to home with clinical changes and limited family support may be visited soon after discharge to update the needs assessment.

Our Case Managers will visit a member discharged to HCBS within 10 business days after an inpatient stay of less than 60 days to confirm that services are being provided without delay or interruption. If there was a significant change in the member's condition, the visit must occur within two business days. However, many of our Case Managers visit members in fewer than 10 days.

The Case Manager also reviews the Care Plan with the member and assists the member in scheduling a PCP appointment if this was not done before discharge. The Case Manager completes a medication reconciliation and may trigger a pharmacy review through our medication optimization program.

Preventing re-admission or facility placement: Aetna Better Health is committed to identifying and monitoring members who may be at-risk for NF LOC or institutional re-admission. We discuss our NF Diversion Plan in our response to Attachment 5 – Section 4.3.12, Question 4. Our assessment and prioritization of the member for services considers risk factors for re-admission.

Coordinating with CBCMs: Our Aetna Better Health Case Managers will lead discharge planning activities for LTSS members. If the member has a targeted Case Manager or a Case Manager in a health home or integrated health home, we will alert them and coordinate the member's discharge. We may convene an ICT meeting that involves members of the member's care and support circle, along with the member.

Policies and Procedures: Prior to contract implementation we will develop policies and procedures on discharge processes for review and approval by the Agency. Policies will address involvement of CBCMs, triggers for assessment, reassessment, and timeframes for Case Management activities.

Attachment 5 – Section 4.3, Question 8 [SOW 4.3.7, 4.3.8, 4.3.8.8, 4.3.8.9, 4.3.8.10, 4.3.8.11, 4.3.8.12]

8. Describe your process for monitoring the effectiveness of the community-based case management process. Provide outcomes from similar contracts in other states, if available.

Our case management monitoring approach

Our program will integrate monitoring of community-based Case Management with our reporting and Quality Management strategies. We monitor member-specific data, population data, and overall trends.

Our care management policies and procedures (P&Ps), management and supervision structure, and protocols promote consistency in member assessment and authorization of LTSS. We will monitor each aspect of our community-based Case Management for LTSS to see that we consistently deliver high-quality care and member experience.

Our approach is to:

- Monitor community-based Case Management through audits, Inter-Rater Reliability (IRR), and trends identified through quality data and member and provider experience surveys
- Track and trend findings from our monitoring program and address them through our Quality Management program. This will improve the community-based Case Management process overall and resolve any ongoing issues of non-compliance or member dissatisfaction
- Remediate gaps in care if we find them for individual members
- Measure overall success of the program

We measure effectiveness of the program through quality-based outcomes such as:

- Improved or maintained functional status
- Improved or maintained clinical status
- Enhanced quality of life and member satisfaction
- Adherence to the Care Plan
- Improved member safety, cost savings, and member autonomy

State Reporting: As required, Aetna Better Health will report to the Agency as required, providing the data reports and analysis in the format and at the frequency required by the State.

Our monitoring process for delivery of community-based case management

Aetna Better Health's quarterly system of internally monitoring member assessment and service authorizations includes:

- Supervisor case reviews
- Report audits
- Standardized chart audits
- IRR

We use the results to support our continuous process improvement strategy, which addresses identified inconsistencies or deficiencies. We document all results; graph the data to look for trends; review the data in team and relevant quality committee meetings; and include the results in the annual LTSS Care Management program evaluations. Our program enables us to identify marginal performance or non-

compliance in the delivery of LTSS services. We describe each component of our monitoring process below.

Supervisory case reviews: Case Management Supervisors review cases to validate adherence to LTSS Care Management P&Ps. These reviews follow a standard format and test if the LTSS Care Management activities have been consistent with LTSS Care Management P&Ps and the standards set by the Agency. For new Case Managers, we review 100% of the assigned cases during at least the first 90 calendar days of their employment. At least quarterly, we conduct file audits for each staff member. We may also review cases:

- For Case Manager performance evaluations
- If the member has recently become eligible for or changed to an HCBS setting
- If there is significant change in medical or LTSS utilization of the member (for example, recent ED activity, discharge from a hospital admission, change in diagnosis)
- To follow up on issues observed in previous audits or case reviews
- To assess member or provider complaints or grievances
- To address questions or complaints from the member, family, caregiver, or PCP

Monitoring care through audit reports: Every month, each case management supervisor runs a standardized audit report from our Care Management Information System. These audit reports profile an individual Case Manager's activities, compliance with timeframes, adherence to P&Ps, and completeness of work. We generate system reports each month for auditing such as the following:

- Iowa InterRAI Assessment System (Initial and Reassessments): Timeliness, Completeness, Accuracy of data entry
- Service-hour calculations, average, outliers
- Appropriateness of services as compared to members' assessed activities of daily living (ADL) and instrumental activities of daily living (IADL) needs
- Options counseling to confirm that the member is in an appropriate setting
- HCBS Service Authorizations: Timeliness, accuracy, consistency with service determination tools and other source data
- Cost-effectiveness Study (CES): Timeliness, accuracy, process compliance
- Caseload Ratio Reports
- Timeliness and number of contacts, timeliness of processes

Monitoring consistency of services: IRR reviews help us provide consistent approaches between Case Managers, consistent application of the InterRAI and other assessments, and consistency in service authorization decisions. Our IRR process and protocols are based on our best practice peer-review approach.

Each Case Manager participates in the program at least annually; once as a Case Manager observer and once as the Case Manager being assessed. Elements reviewed include the InterRAI Tool Assessment System and the Case Manager's evaluation of the member's authorized services, including:

- Home-based supportive care, personal care assistant, chore services
- Scoring of member's activities of daily living needs
- Independent living skills

The case management supervisor develops corrective education plans for any Case Manager who scores less than the 85% standard and monitors the education plans until the required target is met. The educational plans are included their annual outcomes summary report. As needed, we will develop other auditing tools to meet the LTSS program requirements, including the Iowa InterRAI Assessment System, or we will use tools developed by the Agency.

Monitoring for service gaps: Case Managers work with HCBS providers to promote communication and identify potential barriers. This collaboration often helps in early identification of potential service gaps; the Case Manager and provider can then create a plan to resolve gaps before they occur. Management reviews service gaps and non-provision of service logs to identify trends, including possible provider issues or network gaps. Our monitoring includes:

- **Member-reported information:** The Case Manager contacts the member within 14 calendar days of the initial interview to confirm that services have begun. Monthly, the Case Manager follows up to confirm that services are meeting member needs. The Case Manager queries the member on their service delivery using a member update tool. During onsite visits, the Case Manager will also gather feedback from the member. If the Case Manager identifies potential quality of care issues such as squalid living conditions in a residential facility, he or she forwards these to the Quality Management Department for investigation and resolution.
- **System-level information:** We assess gap reports and information from our Care Management Information System and assess service utilization information in QNXT™. We also use data from member grievances to look for potential problems in service quality.
- **Provider-focused verification:** Our Provider Services Representatives will explain to providers that they need to notify Member Services if they cannot deliver the authorized services included in the Care Plan. We will work with providers to implement Electronic Visit Verification (EVV) capability in Iowa as another important tool to identify gaps. HCBS providers must document any non-provision of services in our EVV system. Assigned LTSS staff will review the visit data daily and research any submitted gaps in service.
- **Claims analysis:** Analysis of claims payments helps us verify that services were provided. Because there is a time lag between the authorization and provision of services and the submission and payment of claims, we audit claims data monthly and compare the data with open authorizations to address under-utilization issues. These data reveal whether under-utilization is due to issues with non-compliant providers or if the member was hospitalized, admitted to a rehabilitation or detoxification facility, or was otherwise not in their community residence.
- **Other surveillance:** We also review records to verify that the services billed match those provided and that they are the correct services for the member. Through claims reviews and profiling, we can detect whether members are using other services inappropriately, which might indicate that an HCBS provider is not providing the right service, not providing a service at all, or providing the correct service but doing so ineffectively. For example, if the members served by a particular provider seem to be using the ED more often than members served by other providers, a problem might exist with that provider. When we see such patterns, we investigate the situation to determine the root cause and correct it.

Monitoring Service Limits: Our claims management and QNXT™ system enable us to closely monitor the member's service limits. We use our CES tool to identify necessary services in the HCBS plan and review these as needed. If the member appears to be reaching service limits, we look for other services that may help the member remain at home. For example, we may contact community-based organizations,

access supplemental benefits from a state program, or refer the member to the State Ombudsman. If appropriate, we also notify the Agency that the member is approaching service limits.

Tracking and trending – data and surveys

Tracking and trending to identify systemic issues: We have a suite of data reports that provide our medical management leadership with a comprehensive framework for examining LTSS utilization patterns and trends. We will routinely evaluate various data sources through our Care Management, UM, and Quality Management programs. These reviews identify unusual patterns of use of service or systemic issues in our LTSS program and help us identify opportunities for improvement. Trend reports include:

- Cost and utilization reports, including overall and unit cost metrics
- Care management metrics
- Changes in LOC
- Community-living choices
- Changes in functional status (InterRAI)
- Member complaint, grievance, and appeals data
- CORE reports (stratification of member by risk level)
- Quality CORE (effective upon completion of systems migration in July 2015)
- Provider profiles
- Pharmacy utilization reports
- Inpatient and ED utilization and cost reports
- LTSS reports – facility, HCBS
- Re-admission reports
- Annual CAHPS® or HEDIS® (registered trademark of NCQA) information

Section 10 of this RFP response describes our Quality Improvement programs, which we use to design and implement interventions for any issues that we find through reporting.

Member experience: We use quarterly LTSS member satisfaction surveys to gain valuable feedback from members about their interactions with their Case Managers. The survey asks if the Care Plan and service providers are meeting their needs. During their quarterly face-to-face visits, Case Managers ask the member about adequacy of the Care Plan. We will use both positive and negative responses to review and improve Case Manager processes and clinical performance.

We issue the *Member Experience with Care Management* survey to members after six months of enrollment and annually thereafter. In addition, we will use the CAHPS® survey, which is administered annually. We also analyze and mitigate any complaints that we receive from members or representatives. We will use our findings from survey results and member feedback or complaints to identify and implement interventions, improve clinical performance, and improve member satisfaction. These are part of our Quality Improvement process.

Provider experience: Provider Services Representatives visit providers quarterly. In these visits, the Representatives verify that the provider's necessary licenses and certifications are current.

Aetna Better Health will use provider quality performance reports—also known as provider profiles—to identify trends related to cost, quality, and utilization. Profiles assist both Aetna Better Health and providers in monitoring performance measures for overall care and in identifying members with low compliance or complex health care needs.

Table 4-3 below lists the elements required by the Agency and the tools we will use to monitor each element.

Table 4-3: LTSS Community-based Case Management monitoring capability and results

Question	Requirement	Aetna Medicaid monitoring tool or report
4.3.8.1	Community-based Case Management tools and protocols are consistently and objectively applied; outcomes are continuously measured to determine effectiveness and appropriateness of processes.	• Care Management reports • Care Management Team meetings • Monthly audits • Financial dashboard
4.3.8.2	LOC assessments and reassessments occur on schedule.	• Care Management Information System • Monthly audit • UM reports • File audits • Quality documentation
4.3.8.3	Comprehensive needs assessments and reassessment, as applicable, occur on schedule and in compliance with the Contract.	
4.3.8.4	Care Plans are developed and updated on schedule and in compliance with the Contract.	
4.3.8.5	Care Plans reflect needs identified in the comprehensive needs assessment and reassessment process.	
4.3.8.6	Care Plans are appropriate and adequate to address the member's needs.	Quality documentation file audits
4.3.8.7	Services are delivered as described in the Care Plan and authorized by the Contractor.	• Care Management Information System (Authorizations) • Member contact • Claims • HCBS needs assessment • UM reports • LTSS reports • Claims • Member verification • Provider verification Care gap report • Physician Incentive Plan,
4.3.8.8	Services are appropriate to address the member's needs.	
4.3.8.9	Services are delivered in a timely manner.	
4.3.8.11	Service gaps are identified and addressed in a timely manner.	
4.3.8.10	Service utilization is appropriate.	Audits
4.3.8.12	Minimum CBCM contacts are conducted.	File audit
4.3.8.13	CBCM-to-member ratios are appropriate.	File audit
4.3.8.14	Service limits are monitored and appropriate action is taken if a member is nearing or exceeds a service limit.	• Care Management Information System • Cost-effectiveness Study • QNXT™ • File audit

Remediating member-related problems [SOW 4.3.7]

Aetna Medicaid has multiple interlocking systems to identify and drive remediation of gaps in service delivery. Aetna Better Health will work to prevent these gaps from reaching the member by verifying that all members receiving HCBS have a back-up (contingency) plan that we review quarterly.

Gaps in service: We will work to remediate service gaps by activating back-ups identified in the member's back-up or contingency plan. The Case Manager works with the member and their caregiver to develop the back-up plan and reviews the plan with them at least quarterly. If there is a gap in service that results from a direct care worker's inability to work, the member can activate the contingency plan.

If services are needed and no informal supports are available, the member has specific instructions on how to obtain service. For example, if the gap occurs during business hours, the member may call the Case Manager or the provider directly. If the gap occurs after-hours, the member may call after-hours Member Services. Member Services staff follow preapproved procedures to obtain service for the member. Such services are typically for personal or respite care. The Member Services Representative has 24/7 access to a Health Plan Clinician to provide the member with additional service authorizations to address the gap.

Complaints about quality of care: We address complaints about providers through our Quality Management process. If we receive a complaint about a service worker, we will work directly with the member to try to resolve the issue. This may mean helping to facilitate discussion and resolution between the member and provider. We may also help the member find a different service worker if the problem cannot be resolved. If we receive a complaint, a Case Management Supervisor will review the concern. Our response may include helping to mediate, re-educating the member or provider, helping to find a different provider, or other actions as appropriate for the situation.

Remediating performance findings

If there is an ongoing quality concern regarding a Case Manager, we resolve it through the staff performance review and evaluation process. If necessary, we can help the member transition to a new Case Manager, using the transition process described in this proposal.

Any inconsistencies, omissions, or errors found in the Case Manager audit are documented by the Supervisor for discussion with the Case Manager at the next regularly scheduled meeting or sooner if the issue is urgent. The Supervisor records the results of each audit, tracks and trends inconsistencies, omissions and errors, reports results to the Case Management Manager, and identifies if additional training is needed for the individual Case Manager or the care management team. For Case Managers who continually exhibit performance below expectations, we will take corrective actions, including:

- Additional training
- Reducing case load
- Development of a corrective action plan
- Personnel actions, including transfer out of care management, suspension, or termination

Any systemic findings relating to CBCM performance will be addressed in a performance improvement project or other Quality Management strategy. Our Quality Management Department (described in Section 10 of our response) develops these in close collaboration with our LTSS Care Management Department. We will report our work on these plans and activities to the Agency as required.

Attachment 5 – Section 4.3, Question 9 [SOW 4.3.11]

9. **Provide proposed strategies for ensuring a seamless transition of LTSS services during program implementation. Include a proposed strategy and timeline within which all members receiving LTSS will receive an in-person visit, an updated needs assessment and service plan. Describe how you will ensure services are not reduced, modified, or terminated in the absence of an up-to-date assessment.**

We will facilitate seamless transition to managed care for Iowans

Three Decades of Caring for Those Most Vulnerable

Aetna Better Health recognizes the challenges in moving the complex LTSS population from a fee-for-service system into managed LTSS. We

propose approaches that preserve members' existing Care Plans and relationships until we have completed the assessments and visits necessary to fully understand their needs. We support the Agency's approach that requires continuity of members' caregivers for the first six months to a year after the start of our LTSS program. We also recognize the importance of assisting the provider community with this transition and will recruit current LTSS service providers for our network. We will:

- Focus on continuity of care
- Recognize, respect, and uphold privacy rules and requirements
- Use Case Management handoffs to coordinate transition to enrollment
- Adopt member- and family-centered collaboration
- Supplement where necessary with services of experienced Aetna Medicaid Case Managers and Member Services staff

During and after the transition, we are committed to serving individuals in the communities of their choice within the resources available, consistent with Olmstead requirements. We will support the member with necessary services. We will not reduce enhanced staffing arbitrarily or without first involving the member in a comprehensive assessment and planning process.

We are experienced in carrying out transitions of care for complex members. All of Aetna Medicaid's LTSS plans have continuity of care or transition of care requirements in their contracts, and we have successfully complied with those requirements. Examples from our health plans include:

- **Aetna Better Health of New York** established strategic relationships with several external organizations including those involved in the delivery of HCBS before the mandatory managed LTSS program began. We recognized that we should not disrupt the relationships between the members and the care managers and home attendants. By keeping them in place, we promoted continuity of care and comfort for members. To do so, we collaborated with the existing organizations that were delivering these services and asked them to continue those services while we provided compliance oversight. We leveraged the cultural and programmatic expertise of those organizations and trained them to use Aetna assessment and care management tools, applying the full resources of Aetna to care for our LTSS members.
- **Aetna Better Health of New Jersey** worked with the state and other managed care organizations (MCOs) to create a formal transition plan for implementing the new comprehensive managed LTSS waiver. The health plan hired Case Managers from New Jersey, who became health plan staff. These Case Managers learned to use Aetna tools, documentation policies, and care management approaches. Members kept their Case Managers during and after the transition to managed care. To streamline the transition of Medicaid Advantage plan members moving from a closed plan to Aetna Better Health, the Aetna Better Health Vice President of Medical Management contacted her counterpart at the previous plan and facilitated a Health Insurance Portability and Accountability Act (HIPAA)–compliant process to acquire member names, enrollment, and service delivery information so that Aetna could seamlessly assume the member's care on the first day of enrollment.

Effective startup is critical to the success of our Iowa LTSS program. Table 4-4 shows key implementation processes and specific Aetna Better Health leadership whom we would deploy to implement our program. Our implementation will feature leadership, clinical expertise, state-level and community planning, proactive communications with members, and member-centered transitions. Throughout transition, we will promote the member's dignity and acknowledge and respect the member's culture while maintaining confidentiality.

Table 4-4: Aetna Better Health implementation activities will promote our successful Iowa LTSS launch

Implementation of managed LTSS process	Implementation of our managed LTSS plan
Planning	**Perform thorough analysis of contract and develop strategic plan for Iowa LTSS program and system design, provider network expansions, and key community partnerships** We have been meeting with key community-based organizations and behavioral health, community services, and LTSS advocacy groups in Iowa.
Outreach	**Outreach to consumers, advocates, and providers occurs during planning and through implementation phases** We will develop a presence in both rural and urban areas of Iowa. We have been meeting with key community-based organizations and LTSS advocacy groups. We will set up regional offices throughout the state through short-term leases to support a high-intensity campaign to visit nursing facilities, pharmacies, the AAA, the Arc, adult day centers, AAADs, ACRDs, Supported Employment program, and behavioral health organizations. Our regional offices will also support ongoing collaboration with LTSS providers and activities to bring up the plan, once awarded.
Staffing	**Initial planning and outreach supported by Aetna Medicaid subject matter experts (SMEs) to allow for Aetna Medicaid and managed LTSS plan-specific training** We will work closely with current LTSS providers to carefully coordinate hiring, training, and employment starting dates to support full and continuous services for Iowa LTSS members.
Readiness reviews	**Final program and system design, policies and desktops developed, and staff training in final stages of design, demonstrate program and system readiness to the Agency** We will implement surge-planning processes to supplement our staff during enrollment and initial face-to-face assessments. We will complete testing and demonstrate of our technology offering to the Agency. This phase includes testing and demonstration of the technologies, including demonstrating the many online features for members; showing providers how to view Care Plans; sharing appropriate member information; and establishing HIPAA-compliant Electronic Health Records (EHRs, our Lite-EHR offering, and our management dashboard.
Pre-implementation	**Stratify membership based on initial documentation and enrollment information made available to the plan by the Agency and current MCOs: prioritize group members for contact or assessment at the time of implementation; authorize services per time limits required by contract** If claims data are available to us prior to implementation, we will use our CORE predictive modeling tool to group all members into population health levels to determine the initial acuity levels for each of our new LTSS members. This grouping will be adjusted based on risk scores obtained from face-to-face assessments. If we do not have claims data to work with, we will use Agency-provided data and information gained from the member self-assessment, as well as our outreach process to stratify the membership. Our analysis of claims data and any Care Plans received, including authorization history and concurrent authorizations, is used to see that the member's care continues seamlessly through the transition to a new MCO or upon initial enrollment in the Consumer Choices Option. This comprehensive analysis provides us with pre-launch member prioritization and staffing deployment information.
Implementation and oversight	**Launch health plan LTSS program serving members; audit operations (for example, authorizations, claims payments, assessments, Member Services, grievances and appeals, quality of care)** Our experienced Implementation Team will be in Iowa, overseeing implementation processes and working closely with our plan's staff and functional areas, monitoring compliance and timelines, and providing ongoing technical assistance for several months post-launch.

Implementation of managed LTSS process	Implementation of our managed LTSS plan
Modify program and system design	**Modify program processes based on oversight and Agency, consumer, provider, and advocate feedback** We will continue to evaluate, modify, and enhance our program design based on new Agency requirements, advanced technology solutions under development, member and provider recommendations, quality committee recommendations, lessons learned, and best practices from our other LTSS health plans in operation now. We will perform ongoing monitoring of every aspect of the program to identify areas of continuous process improvement for LTSS program activities.
Ongoing engagement	**Engage members, providers, advocates, and the Agency as we focus on program and systems design and improvements** We engage all stakeholders in an ongoing process throughout every functional area of the plan. Our Provider Services team will work face to face with the LTSS providers to support smooth transitions and financial-processes education. Member-facing engagement, which is paramount to promoting the best health outcomes for our LTSS members, takes place throughout our organization and involves care coordination processes, ICTs, 24-Hour Nurse Line, Member Services, Crisis Lines, Peer Outreach, and our online and mobile technologies.

Our strategy for providing continuity of care for members

Our goal is to be prepared to serve the member appropriately and effectively on the day of enrollment so that the member does not experience any gaps in care. We may have limited contact with members until the start of the Contract. Until then, Aetna Better Health will work within the scope of HIPAA regulations to prepare to accept the new member and arrange for appropriate LTSS and other services and supports. Our Case Managers coordinate with referring agencies and facilities to identify any services the individual is currently receiving and arrange for them to continue, if appropriate, upon enrollment. Although we do not directly contact individuals or their families or caregivers prior to enrollment, if they contact us we will respond appropriately, providing requested information or referring them to the appropriate Agency representative.

Before the start of the program, we will conduct extensive outreach to providers currently providing LTSS services to encourage them to participate in our network. At Contract start, the Case Management Team will contact the member, family or caregiver, or authorized representative to confirm that services are in place and authorized. Our Case Manager also conducts an assessment, if necessary. In accordance with Agency requirements related to transition periods, we will inform all members of their transition services and their providers and obtain agreement on the Care Plan with the new member and representative. We will enter the necessary provider service authorizations for transition services.

We will see that that Iowa LTSS members continue with the Medicaid services, Care Plan, and support services they had been receiving at the time of enrollment with our plan, both with contracted and non-contracted providers. We quickly contact current LTSS providers to bring them into our network to preserve continuity of care. We commit to Agency requirements:

- Services may not be reduced, modified, or terminated in the absence of an **up-to-date assessment of needs** that supports the reduction, modification, or termination. [SOW 4.3.11]
- Member shall be permitted to **retain their current CBCM during the first six months of transition** to managed care and will receive advanced notice of planned transitions initiated by Aetna Better Health in accordance with documented P&Ps [SOW 4.3.4]
- For individuals with enhanced staffing to support them in a less-restrictive setting, **we will not reduce staffing arbitrarily** or without documenting a reduction in clinical needs. [SOW 4.1]

Other Contacts: We may increase the frequency of member contacts based on the members' needs. Each contact includes review of the Care Plan and other elements of the visit described in this proposal.

- **HCBS members:** Quarterly face-to-face visits, monthly calls
- **Members transitioning to HCBS from facility:** Face-to-face visit to the member within two days of transition to the community; visit every two weeks for the first two months from discharge; visit once per month for the first year after transition
- **NF and ICF/ID:** Initial face-to-face visit within 30 days unless prioritized by need; face-to-face visits every 180 days after start, and as needed
- **Any LTSS member discharged from acute facility stay of 60 days or less:** Telephone contact within 72 hours and visit as needed
- **Member disenrolling from self-direction:** Voluntary: face-to-face visit within seven days of request to disenroll; for involuntary: within two days of notification of Agency decision

4.3.12 Nursing facilities and intermediate care facilities for individuals with intellectual disability (ICF/IDs)

Attachment 5 – Section 4.3.12, Question 1 [SOW 4.3.12.1]

1. **Describe proposed strategies for providing care coordination services for residents of nursing facilities and ICF/IDs, including the timelines and frequency of in-person visits.**

SERVICES FOR MEMBERS IN NURSING FACILITIES AND ICF/IDS

Relationships are important – both with the member and the member's facility-based caretakers. Our approach uses a dedicated Case Manager to support members residing in NFs and ICF/IDs. We will coordinate services for members in nursing facilities and ICF/IDs by developing relationships with the member and family and the facility-based caregivers. We will use these relationships to improve quality of life and care for the member, and identify opportunities to help the member transition to the community. Our strategies are:

Designating facility-based Case Managers: To the extent possible, all of the members in a specific facility are assigned to the same Case Manager. This enables the Case Manager to develop deeper knowledge of both the members and the facility. Once facility staff learn that can we offer them solutions, they are more than welcoming. We have already begun contacting Iowa facilities to discuss contractual and care management relationships.

Participating in the care planning process: We participate in facility care planning activities either as the lead or as a collaborator. We participate in facility rounds on a regular basis. Our Case Manager identifies any concerns that the facility staff might have about the member. The Case Manager documents these concerns and works to resolve them. The assigned Case Manager will facilitate ICT meetings, facilitating and coordinating transition plans with input and guidance from the Aetna Better Health MFP Liaison.

Serving as expert consultants and advocates: We will be advocates for the member and work with the facility staff to identify symptomatic triggers before conditions worsen; these include pre-emptive identification of hydration, nutritional, skin, and fall risks. We use various methods to share information with facility staff. For example, we can arrange seminars on topics such as reducing fall risks, the importance of hydration, and other topics that support the facility's goals for continuing education.

Promoting a discharge-oriented Care Plan: Our Case Managers will coordinate with facility Case Management staff to review the member's Care Plan, make adjustments as needed, and collaborate on discharge planning. Case Managers will participate in NF/SCNF interdisciplinary team meetings, assess transitional service needs, and authorize and procure assessed transition services.

Integrating physical, behavioral, and long term care needs: We will apply our ICM approach to assessment processes to identify member strengths; issues; and physical, behavioral, and long term care needs. Our comprehensive Care Plan for the member will address each of these needs and identify solutions to improve quality of life for the members. We will use an ICT to bring in perspectives and solutions from experts and include the member in the discussions.

Improving quality of life for members not transitioning: Our Case Manager works together with the facility staff to align the member's goals and treatment plan through safety, medication management, and treatment plan compliance to improve outcomes and status. During our visits, we will evaluate health, functional status, and quality of life of the member and assess potential for community-based living.

Preventing hospitalizations: Our model brings a high level of flexibility to extend benefits to "manage in place" to improve member quality of life and health status. For example, after a member's Medicare benefits expire, we might authorize additional physical therapy, occupation therapy, or speech therapy to allow a member to remain in the NF during treatment in lieu of a hospital stay. We will explore use of Nurse Practitioners to provide primary care services to members in facilities. This coordination of care reduces avoidable ED and hospital admissions and improves the quality of life for our members residing in SNFs.

Monitoring quality of facilities: Our Case Managers track and respond to reports or complaints from the member and his or her family and other caregivers regarding facility quality. Each Case Manager is trained on how to report critical incidents. Our P&Ps specify what actions must be taken for urgent and non-urgent quality concerns. We track quality concerns through our Quality Management process. The Case Manager may escalate an issue to our Chief Medical Officer or Network Management team if there appears to be a pattern of quality gaps or if he or she cannot directly resolve the issue with the facility. The LTSS Care Management Department will participate with the Provider Service and Contracting departments, along with NF or other LTSS providers, to discuss and resolve issues as necessary. Such issues may include member-specific issues, billing concerns, claims, authorizations, or any others. We will track and promptly resolve all issues.

PROPOSED TIMELINES AND FREQUENCY OF VISITS

For members in nursing facilities at the time of Contract implementation, an Aetna Better Health Case Manager will make an initial visit and assessment within 30 days. After that, we will conduct face-to-face visits at least every 180 days and whenever there is a need for reassessment. For pediatric members in SNFs, we will make face-to-face visits every 90 days. We will be responsible for nursing facility members' options counseling and transition activities when a member has been identified through the quarterly screening of MDS Section Q, Participation in assessment and goal setting, to return to their home and/or community of their choice.

Attachment 5 – Section 4.3.12, Question 2 [SOW 4.3.9, 4.3.10, 4.3.12.2, 4.3.12.3]

2. Describe processes for working with nursing facilities and ICF/IDs to coordinate care.

WORKING WITH NURSING FACILITIES AND ICF/IDS

Our program to coordinate care for members in nursing facilities and ICF/IDs proactively identifies members who could transition to less-restrictive settings and improves quality of life for long-term residents. Aetna Better Health will work continuously to improve processes through our Quality Improvement activities and committees. The challenges, lessons learned, and successes of our health plans provide us with real-time experience and clarify opportunities to consistently innovate on behalf of our Agency partners and members. Aetna Medicaid's years of experience in serving the LTSS population allow us to identify barriers to optimal care and to develop improvement strategies to address these.

OUR PROGRAM TO PROMOTE APPROPRIATE ADMISSIONS

The Aetna Better Health LTSS Care Management Team reviews all NF admissions at several levels. This is an added level of protection to prevent members with a mental illness or developmental disability from inappropriate placement in an NF or SNF. We see that necessary clinical and administrative documentation is in place; documentation must show that the member was counseled on placement options. If we ***cannot place the member in the location he or she requests, we will meet with the member to discuss options.*** We identify alternate placement options and develop contracts to meet the needs of members with special needs or who choose to live in an assisted living facility or NF not yet contracted.

Delaware – Learning to work with facility staff

Challenge: While the initial enrollment for the NF membership was 57% of our population, many nursing facilities openly opposed transitioning the LTSS program to the MCOs. We were initially concerned that the facilities might be reluctant to allow contact with our members and access to the information that Case Managers would need to initiate our assessment process.

Lessons Learned: To foster positive relationships, Supervisors and the Program Manager assigned and introduced a single Case Manager to each facility (or group of facilities with the same owner) during the first week of implementation as the key contact and held FAQ sessions.

Successes: Facility staff appreciated the opportunity to ask questions and address concerns, which simplified their adoption of the new process and new plan.

Our options counseling process and attestation forms document the following:

- The reasons why facility placement is being considered or requested
- Options for and available services that may enable the member to remain in a community-based setting
- Identification of an alternative facility or community-based residential setting
- Discussion and education of the member or the member's authorized representative of at least two HCBS residential options

When the member is admitted to an NF:

- We document that PASRR requirements have been met prior to the member's admission.
- We complete PASRR Level I screening and evaluation and as applicable, a level II PASRR evaluation, to guide appropriate placement in the least-restrictive setting possible.
- We inform members of the option to receive HCBS in more than one residential setting appropriate to their needs.

OUR POLICY TO PROVIDE APPROPRIATE TRANSITIONS BETWEEN FACILITIES

We acknowledge this Agency requirement. We will develop and implement P&Ps stating that we will not transition NF, ICF/ID, 1915(i) Habilitation, or 1915(c) community-based residential alternative residents to another facility or residence unless:

- The member or the member's representative specifically asks to move.
- The member or the member's representative provides written consent to move based on quality or other concerns raised by the contractor, which shall **not** include the residential provider's rate of reimbursement.
- The provider has chosen not to contract with us.

When a member wants to move to a new NF that is not in our network, the current Case Manager is responsible for the member until the situation is resolved, if a new Case Manager will be taking over the member's case. In the interim, we will offer a selection of contracted facilities for the member to consider or offer to change program contractors for the member. The Case Management Supervisor reviews all documentation to provide adherence.

Florida – Early notification improves facility diversion

Challenge: Our Florida plan discovered that while we had high (96.02%) baseline retention rates for our Long Term Care Community Diversion program, members who voluntarily disenrolled were often admitted to an NF without our knowledge or involvement.

Lessons learned: We educated caregivers, assisted living facility providers, and facility staff on the importance of timely health plan notification prior to member admissions and made it clear that measurable improvements in timely notification would allow us to re-evaluate the member's needs and identify the optimal, least-restrictive care setting while improving the likelihood that any future admissions were to a participating facility.

Successes: This education created better opportunities for nursing home diversion, enhanced member retention, and increased the member satisfaction rate to 98.25%.

APPROACHES TO PREVENTING INVOLUNTARY DISCHARGE

We acknowledge this requirement. We will implement a facility contract requirement to protect the member from involuntary discharge that may lead to placement in a more-restrictive setting not of the member's choice. We will submit this requirement for review and approval by the Agency. If the member is transitioning into the community, our goal is to make it a planned transition, with all of the necessary services, supports, and supplies needed by the member. If we cannot successfully transition the member to the community, we will identify another facility that is willing to admit the member. We will also connect the member and family with community resources that can assist, as well as the State Ombudsman. We will always document our efforts and focus first on the member's needs.

We try to proactively prevent involuntary discharges. Our network contracts clearly define the acceptable reasons for discharge and those reasons that are not acceptable. The contracts also specify the notification requirements. At the member level, we participate in NF care rounds to identify clinical, social, and financial issues impacting our members. If we learn that the member is at-risk of involuntary discharge due to non-payment of patient liability or any other reason, we work to identify other options through the care planning process. Our Integrated Care Team will work with the member to identify available supports and creative strategies. We would assess financial status, family support systems, community placement options, or other facilities.

INTERFACING WITH STATE RESOURCE CENTERS [SOW 4.3.12.3]

We recognize that State Resource Centers (SRCs) may provide necessary services for very complex members. We acknowledge that the SRC superintendent has the final determination as to whether or not to admit a member to the SRC. ***In keeping with the Connor Consent Decree, we will develop programs and processes that help members live in the community of their choice in the least-restrictive setting***. We have been very successful in supporting members who wish to stay out of residential facilities. For those already in residential treatment programs, we have helped them transition to appropriate community settings.

Our Case Management assessment and documentation process will verify that we have assessed the member's needs, discussed possible options, and worked to identify alternative placements. We will develop P&Ps to address the necessary communications and interactions with all Iowa facility types, including NF, IRC, SRC, IMDs, and ICF/IDs. Case Managers will receive training on these P&Ps. As required by the Agency, we will fund diversion referral activities to divert SRC admissions into community settings through additional or increased community support, identification of informal support, or paid attendants. For members with a potential admission to the SRC, we will see that a staff member knowledgeable about residential and non-residential resources is a member of the care coordination team. From the day of admission to the SRC, we will begin working on a discharge plan to transition the member from the SRC. The member's case may also be presented at interdisciplinary care coordination case rounds.

FUNDING OF COURT-MANDATED PLACEMENTS [SOW 4.3.12.3.6]

Aetna Better Health acknowledges this requirement and will address our care coordination expectations for these members in organizational policies. We currently fund court-mandated placements in our Arizona plan and are experienced in the financial and administrative requirements.

UTILIZATION MANAGEMENT REVIEW OF INSTITUTIONAL FACILITIES [SOW 4.3.12.7]

We will establish criteria that support delivery of needed care and services to LTSS members. These LTSS-specific criteria will supplement our standard acute care criteria. We acknowledge that national medical necessity criteria have not yet been established for LTSS, including long-stay NF services and most HCBS, such as attendant care, personal emergency response system, or in-home respite care. However, our criteria will consider whether each member meets institutional LOC criteria and continues to be eligible or can become eligible for the Iowa LTSS program.

Because of our dedicated facility-based Case Managers, the Case Manager develops positive relationship with discharge planners and participates in case rounds to identify pending UM decisions. When member needs dictate hours of service over and above our standard thresholds, a supervisory review will be conducted to assist the Case Manager and discuss and identify any additional options that may be more cost-effective. These options can be discussed with the member or ICT. These alternatives will consider the member's preferences and preference for community-based settings. The criteria will not be more restrictive than any other requirements or conflict with our Contract with the Agency.

Our UM program will be applied to nursing facilities; nursing facilities for persons with mental illness; ICF/IDs; Psychiatric Medical Institutions for Children; Independent Mental Health Institutes; and hospitals. All members identified as requiring specialized services will be included in our utilization review sample and reported to the Agency. We acknowledge and will comply with requirements for

review of residential facilities: annual onsite review; desk review every three years; exit conference; and report and corrective action steps within 30 days.

Attachment 5 – Section 4.3.12, Question 3[SOW 4.3.12.1]

3. Describe strategies for coordinating physical health, behavioral health and long-term care needs for residents and improving the health, functional and quality of life outcomes of members.

IMPROVING MEMBER QUALITY OF LIFE IN LONG-TERM CARE FACILITIES

Three Decades of Caring for Those Most Vulnerable

Our proposed LTSS program incorporates specific strategies to improve the quality of life for each enrolled member and his or her caregivers. We will assign an experienced Case Manager as a single point of contact for the member and family. We develop an individualized Care Plan with the member and the ICT to guide the member's care and services. The member and member's family participate as experts on the team. We support members' physical and mental health through our care management programs, immunization initiatives, medication optimization, fall risk reduction, advance directives, and maintenance of skin integrity. In Iowa, we will explore options for value-based payments for residents in long-term facilities based on facility performance.

To improve health, functional, and quality of life outcomes for members, we will implement:

Interdisciplinary Care Team meetings: All LTSS members are invited to participate in ICT meetings, with participants chosen specifically by the member. ICT meetings can be instrumental in efforts to manage challenging behaviors, frequent ED visits or hospitalizations, or other complex cases; the meetings can also develop interventions to improve quality of life. The member's Case Manager facilitates ICT meetings for all assigned members. The ICT discussions may include any physical health, behavioral health, and sociocultural factors that are affecting the member's overall health. Based on member needs, the team members can leverage their expertise in physical and behavioral health, LTSS, and social and community services.

Dedicated Facility Case Managers: Our facility-based Case Manager program offers us a mechanism to provide regular, ongoing physical and mental health management for our members receiving care in nursing facilities. We will explore the potential to place Nurse Practitioner Case Managers in residential facilities in Iowa. This model has been very successful in other states; Nurse Practitioners can serve as the members' PCP as well, which greatly improves access to care. ***Facility Case Managers gain knowledge of our members' needs and develop trusting relationships with the facility staff; they are able to respond in a timely manner to potential changes in a member's condition***. This service supports early identification of member needs and the development and implementation of strategies to improve quality of life, health, behavioral health, and functional status. Case Managers will be available daily in facilities with numerous Aetna Better Health members and will make onsite visits regularly to facilities where we provide coverage to only a few members.

Medication optimization: Members transitioning out of nursing facilities often have high numbers of medications and complex medication schedules. This medication schedule can affect the member's mental status and health in a facility and often presents a barrier to community living. ***We will review the member's medications to reduce complexity, optimize effectiveness, and minimize adverse effects*.** Sometimes this simplification can have a dramatic effect on the member's ability to transition to the community. If needed, we will consult with an Aetna Better Health pharmacist to assess for medication interactions, right prescription, potential adverse effects that affect community living, and other factors.

The Case Manager can trigger a medication optimization review at any time, including prior to transition of care before a medication error adversely impacts the member.

Skin and Fall Evaluation (SAFE) program: We propose to bring to Iowa two successful programs that improve quality of life for LTSS members in nursing facilities and HCBS. Since 2007, Aetna Medicaid has been offering the SAFE program in our Arizona health plan. Members who are in home, community, and assisted living settings are assessed for skin integrity and fall risk using the SAFE tool at each visit. We offer education to members and caregivers and recommend potential prevention strategies for institutional staff. In addition, the InterRAI Assessment includes fall risk, nutritional status, and skin integrity. The InterRAI results trigger evidence-based interventions to address these areas. Based on the InterRAI findings, we will evaluate the need for additional assessments or services.

Our Arizona plan increased their skin and fall risk assessments from 67% at the start of the program, to more than 98% of visits.

Advance directives: Aetna Better Health Case Managers have been trained on advance directives, the effect they can have on a person's life, and program requirements for advance directives data collection. Case Managers routinely bring copies of advance directive forms to their members' homes and provide continuing education to the members and their families about the importance of having these documents completed. At each review, our Case Managers encourage the member/family to determine their preference for advanced directives. We track monthly progress on the overall percentage of members with completed advance directives.

Attachment 5 – Section 4.3.12, Question 4 [SOW 4.3.12.4, 4.3.12.1]

4. Propose institutional diversion strategies and describe successes in other states.

OUR PROACTIVE SERVICES STRIVE TO KEEP MEMBERS OUT OF INSTITUTIONS

Three Decades of Caring for Those Most Vulnerable

We propose an NF diversion program that will help members stay in the least-restrictive setting that can meet their needs and save money by promoting HCBS. Since 1998, Aetna Medicaid has been successful in diverting members from institutional settings and transitioning members from nursing facilities into their own homes or into community-based settings with HCBS. Aetna Medicaid's NF Diversion and Community Rebalancing goal is to decrease the reliance on institutional settings for the provision of LTSS, while promoting the member's dignity, choice, and autonomy.

We will develop a detailed NF Diversion Plan to prevent unnecessary or inappropriate NF admissions. In addition, we will develop diversion strategies for specific populations:

- Members waiting placement in a nursing home, ICF/ID, or other institutional setting, including members who may be on an HCBS waiver waitlist
- Members who have a change in circumstance or deterioration in health or functioning and who request NF or ICF/ID services
- Waiver members admitted to a hospital or inpatient rehabilitation program
- Individuals in an NF for a short-term stay

Our strategy for diverting avoidable long-term admissions will include:

- Close monitoring of member status. For example, members admitted to a NF for short-term stay must be evaluated prior to the end of skilled stay for a discharge plan and identification of needs so the member can be discharged when clinically ready.
- Contracting with specialized providers. This may entail establishing incentives for effective providers and enhancing care to include face-to-face visits for reassessments to address care needs when condition changes.
- Collaboration with concurrent review, hospital, or facility staff, using our re-admission reduction strategies.
- Training staff on early identification of member's health decline to promote early intervention.

Aetna Better Health will collaborate internally and externally in NF diversion efforts. Our approach includes:

- Facilitating appropriate communication among providers and the plan
- Training health plan and provider staff for early identification of members that may be candidates for the NF Diversion program for referral for diversion services that may prevent members from being prematurely institutionalized
- Educating our Member Services staff, concurrent review, prior authorization, and LTSS Care Management staff on our approach
- Performing assessments and screenings to identify member needs for successful community living
- Following up on care management activities to sustain members in community living
- Targeted members for diversion activities include:
- Members awaiting admission to nursing facilities to attempt to provide community supports through HCBS when members choose HCBS
- Members in the community, including those residing in their own homes, and those residing in assisted living facilities, who have a negative change in circumstances or deterioration in health or functional status and are requesting NF services
- Members who are admitted to a hospital or inpatient rehabilitation facility who do not reside in an NF
- Members placed on a short-term basis into an NF regardless of payment sources

Aetna Medicaid's **Nursing Facility Diversion program will not prohibit or delay a member's access** to NF services when those services are medically necessary and requested by the member. The Plan will comply with requirements established by the Agency. We will submit the Plan for our program to the Agency for review and approval prior to implementation.

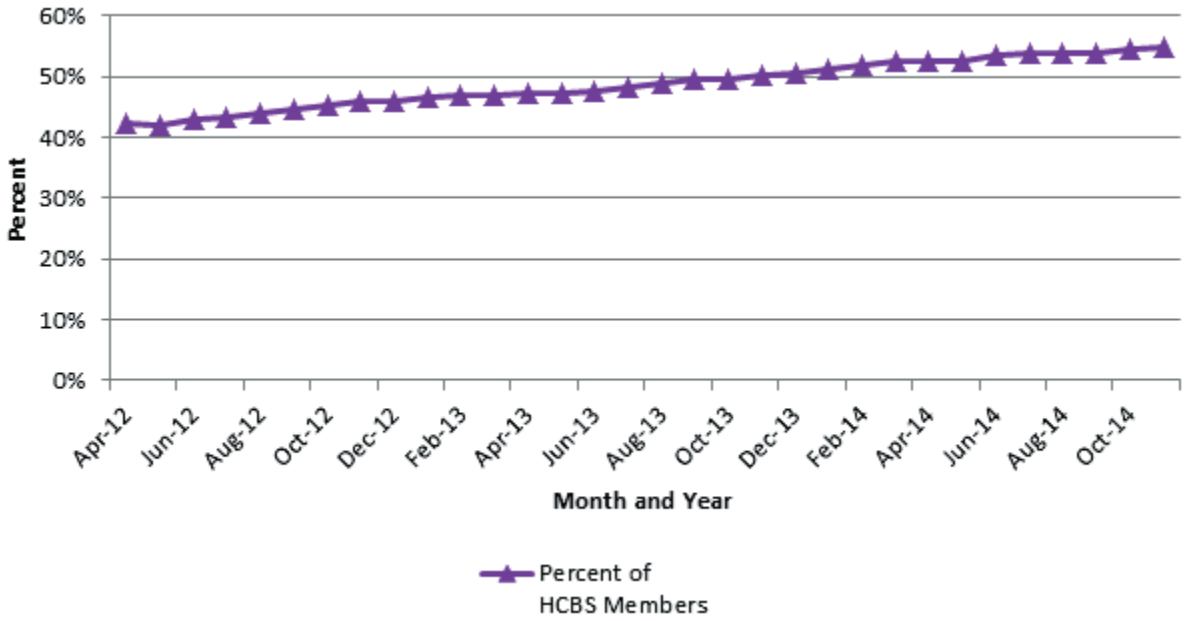
RESULTS OF AETNA'S INSTITUTIONAL DIVERSION PROGRAMS IN OTHER STATES

Our longest-term success story is from our Arizona plan. Results from Arizona illustrate the plan's efforts to both move members out of institutions and prevent new admissions. In the initial years of managed care, our plan in Arizona saw significant gains in HCBS services compared to institutional services. As facilities, providers, and members have adapted to managed care programs and processes, improvements have leveled. As Figure 4-3 shows, results continue to demonstrate the impact of managed care in diverting members to community-based services.

We achieved dramatic improvement of the HCBS ratio in Arizona:

- From 1993 - 2002, the ratio improved by an average 3% per year
- From 2003 - 2008, the ratio improved by an average 2% per year
- From 2009 - 2012, the ratio improved by an average 1.2% per year

Figure 4-3: HCBS ratio improvement in AZ



Attachment 5 – Section 4.3.12, Question 5 [SOW 4.3.12.5]

5. Propose strategies to identify members who have the ability or desire to transition from a nursing facility or ICF/ID setting to the community. Propose assessment tools, provide a sample transition plan and describe post-transition monitoring processes.

OUR TRANSITION PLANNING AND CAPABILITIES

Aetna Better Health will develop and present an NF-to-Community-Transition-Plan to the Agency for approval prior to Contract start and will present it annually thereafter for review and approval. Aetna Better Health Case Managers will be responsible for identifying potential candidates in facilities who may be safely transitioned back into the community.

We will use tools developed in Arizona in the Iowa MFP program, or alternatively, we will use our own assessment tools after having them approved by the Agency. Our Transition plan will be based on approved policies and procedures that identify:

1. Mechanism by which the member's assigned Case Manager sees the development of a coordinated and seamless transition plan through engagement of or participation in an Interdisciplinary Team consisting of NF/SCNF staff, other providers or authorized representatives, and caregivers as appropriate
2. Our responsibilities and methods for identifying candidate members
3. Protocol for how the assigned Case Manager assesses the member's transitional needs, including the authorization for payment and procurement of transitional services
4. Mechanisms identifying how Aetna Better Health will monitor the effectiveness of the NF to Community Transition Plan including performance measures such as ED visits, hospitalizations, re-hospitalizations, and other quality measures as required by the state to meet federal reporting requirements of the MFP demonstration
5. Overview of the quality assurance and performance improvement strategies used by Aetna Better Health to address identified trends in member outcomes in individuals who have transitioned from an NF to community
6. Details on how Aetna Better Health will align with or incorporate Iowa's existing MFP materials and resources into our program

Successful Protocols

Our Delaware health plan has developed and successfully used a brief cognitive assessment protocol that helped drive very successful results in transitioning members to the community. The tool was an effective starting point for the discussion of whether members were able to successfully transition to the community. This tool helped Case Managers identify if members needed assistance to make a decision or if a power of attorney was necessary. After the assessment, the Case Manager, member, and caregivers talked about what services were available, how the member's needs could be met in a different setting, what it would look like; they then talked with the member's family or representative to provide information. They specifically targeted members who were performing their activities of daily living independently or with minimal assistance, as well as those members who identified a desire to return home.

The Aetna Better Health Transition Plan will ***document Care Management responsibilities*** for:

1. Identifying members who may be appropriate for community transitions including those who may qualify for transition under the MFP demonstration program from an institutional setting back into the community.
2. Conducting a transition assessment, using tools preapproved by DHS, including at minimum, an assessment of the member's desire and ability to transition to the community as well as an identification of risks. The assessment also evaluates the opportunity for the member to enroll in a 1915(c) HCBS waiver, in which case the needs assessment and Care Plan requirements described in Section 4.5.2 shall apply.
3. Referring potential community transitions or MFP candidates to MFP Liaison to oversee the transitional process.
4. Active participation in the NF/SCNF ICT meetings to develop a member-centric community transition plan. In the plan, address all transition needs and services necessary to safely transition the member to the community including: (i) physical and behavioral health needs; (ii)

selection of providers in the community; (iii) housing needs; (iv) financial needs; (v) interpersonal skills; (vi) safety; (vii) other barriers.

5. Coordination with the member, family, NF/SCNF staff, and MFP Liaison/Community Choice Counselor (CCC), as appropriate, in the identification, approval and purchasing of the necessary Transition Services.
6. Coordination with the member, family, NF/SCNF staff, and MFP Liaison/CCC to coordinate a Care Plan including authorization of services to begin upon discharge.

OUR CASE MANAGERS WILL ASSIST MEMBERS MOVING TO THE COMMUNITY

We bring our experienced transition processes to Iowa. Aetna Better Health will provide our members with timely access to necessary services in an appropriate setting and at the right LOC. If a member is identified as moving to the community, our Case Managers will work closely with each member and family, the PCP, and other providers plan a successful, sustained transition. We have a variety of tools available to assist member transitions, including the *I Choose Home* materials, training materials, and our Options Counseling documentation from our Case Management Information System. We will use Iowa's assessment and planning tools if required.

Member identification and options counseling: Our Case Managers are trained to review responses that identify members interested in training from a facility to the community and are skilled in identifying these individuals. Case Managers will inform members of their choices related to living in the community rather than an NF, as well as the types of services that will be available to them in the community. We will encourage members to select options best suited to their preferences, living arrangements, and support system. We will also complete a risk mitigation assessment that outlines the member's strengths and potential concerns for moving the member into a lower LOC, and identifies any behaviors that may interfere with the member's ability to become fully functional in the community setting.

Medication optimization:
For stable HCBS members in the community, Aetna Better Health offers a routine medication optimization review for members with complex regimens. Our Case Management Information System flags these members for further follow-up by the Case Manager or Clinical Pharmacist. Where needed, we offer a visit with an Aetna Clinical Pharmacist, either at a local pharmacy, by telephone, or by Skype to simplify the medication regimen and eliminate duplication. Aetna Better Health has special initiatives to safeguard appropriate use of pharmaceuticals. For LTSS members discharged home with controlled substances, we will implement a pharmacy review. We also alert the State that we will monitor for frequency and location of refills and have the capacity to refer the member to a pharmacy lock in program if needed. For children using prescribed amphetamine-related medications at home, we flag the case for monitoring. Our processes make certain the member gets the drug as prescribed with no diversion. If needed, the member may be referred to a health home or be followed by a Case Manager specializing in pediatric issues.

Transition plan: We develop a member-specific transition plan to support the member in successfully moving into the community, which becomes a part of the member's Care Plan for LTSS. It covers:

- Services and supports that are needed to support the member in the least-restrictive community setting

- Comprehensive care for chronic conditions, such as diabetes, cardiovascular disease, and asthma, using evidence-based clinical guidelines
- Clinical preventive services, including adult screenings, such as mammograms or colonoscopies
- Non-Medicaid-covered community services and supports to improve health and quality of life
- Supported employment or meaningful volunteer work for members who would like this experience

Please see Appendix E for the transition plan.

Coordinate home-based services: Throughout this process, our Case Managers will facilitate the coordination of all services identified in the individualized Care Plan and clearly define areas of responsibility. We will continually assess and reassess the effectiveness of interventions that are the centerpiece of the Care Plan to verify that needed services are delivered on a schedule that is outlined in the member's Care Plan and in an appropriate setting. Case Managers continuously work with the member to identify and overcome barriers to independent living. For example, we may arrange for solutions such as ramps, handrails, a raised toilet seat, in-home therapies, and transportation. We help the member identify formal and informal caregivers through the provision of respite care, support group referrals, and family counseling. Aetna Better Health will also monitor receipt of services.

Intensive Care Management for post-transition monitoring : Aetna Better Health will offer stepped-up ICM to members transitioned from an institution to the community and will meet the requirements for face-to-face visits. Members who have transitioned from institutions to community-based settings have the opportunity for improved quality of life but also have a risk of being re-institutionalized. Our Case Managers will make a face-to-face visit to the member within two days of transition to the community, every two weeks for the first two months from discharge, and once per month for the first year after transition. We may increase frequency as needed due to changes or instability in the member's circumstances.

In Arizona, the health plan implemented interventions to more effectively move members into the community and sustain them there. The program included:

- **Transition fund** – The Community Transition Service is funded through the state Agency. It helps members who reside in institutional settings integrate into the community by providing funds to help cover basic home necessities. This fund provides financial assistance to members who have resided in an NF for at least 60 consecutive days.
- **Expanded home modifications** – Implemented processes for approving expanded home modifications (ramps, roll-in showers) to improve independence for members with accessibility and mobility issues.
- **Home Physician program** – Provided in-home physician services within 24 to 48 hours of discharge to members transitioning from nursing facilities.
- **Skilled Nursing Facilities (SNFs)**– Re-allocated Case Management caseloads to assign specific Case Managers to designated SNFs to promote regular face-to-face contact with the members in each facility.
- **Administrative assistance** – Assistance with Supplemental Security Income applications, other funding sources, or community services such as food stamps to assist in sustaining the member in the community.
- **Job search** – Assistance identifying meaningful employment for members who wish to work.

These interventions resulted in improvements that exceeded the Arizona agency's benchmark. We will develop innovations that build on community and clinical capabilities to achieve similar results in Iowa.

Attachment 5 – Section 4.3.12, Question 6 [4.3.12.5]

6. **Describe processes for interacting with the State's MFP designee and strategies to prevent duplication and fragmentation of care.**

CASE MANAGERS HELP MEMBERS ACCESS MFP SERVICES

The Iowa MFP program interfaces directly with the planned Aetna Better Health Care Management program. In our proposed program, we will designate an LTSS Care Management Supervisor as the Iowa MFP Liaison. ***Our liaison will be responsible for all issues related to community transitions and the Iowa MFP Program.***

We acknowledge that Iowa's MFP designee will be responsible for the authorization and delivery of non-Medicaid-covered services and that we will be responsible for the authorization and delivery of Medicaid-covered services.

Through our coordination and oversight, we will make reasonable efforts to see that services are not fragmented or duplicated for the member. We will be prepared to transition activities to Aetna Better Health as needed when the Iowa MFP grant is completed. We will conduct assessments, care planning, and post-discharge monitoring.

Specifically for MFP, our Case Manager will submit the MFP eligibility form to the MFP Liaison after conducting the required assessments and counseling. Once approved by the MFP program, the Case Manager will participate in the member's ICT meetings and other communications necessary to promote the member's seamless transition to the community. The Case Manager will work with the MFP Liaison to identify, approve, and authorize all transition services prior to the member's discharge from the facility.

Aetna Better Health will track all MFP-qualified days for MFP participants and notify the MFP Liaison using the MFP 76 form of any triggers that would stop the MFP clock or disqualify a member from the program. All MFP-required reports will be submitted quarterly to the Iowa MFP Program Director or as prescribed by the state. This will include all qualified transitions for those under age 65 and those 65 or older.

All members who qualified but did not transition due to their not meeting the Cost Efficiency of Care/Cost-effectiveness Analysis test will also be reported. We will work with the Agency to implement any additional quality or outcome measures as required by the MFP Operational protocol.

Attachment 5 – Section 4.4, Question 1 [SOW 4.4.2 and all sub-elements, SOW 4.4.3 and all sub-elements]

1. **Describe in detail how service plans meeting contractual requirements, state and federal regulations, and all applicable policies, will be developed for each member enrolled in a 1915(c) HCBS waiver.**

Aetna Better Health proposes to use our integrated information system; our standardized, Agency-approved assessments; and our person-centered planning process to develop comprehensive care and Care Plans for HCBS members in Iowa.

Planning will be carried out by our Case Managers who have expertise in the member's condition and with training needed fully engage members in the process. Our information management tools and audit processes will enable us to track compliance with State and federal regulations and Contract policies.

We will use a collaborative process to provide options and to support members' independent living goals. Our HCBS care management process provides members with information and supports to enable greater self-sufficiency in the areas of housing, education, and employment. We support the member and his or her family in making informed decisions. We coordinate a continuum of service options that support the expectations and agreements established through the care planning process. Our process is built upon a respect for the member's preferences, interests, needs, culture, language, and belief systems.

Aetna Better Health Case Managers play an integral role in this process.

- Case Managers are responsible for coordinating HCBS by engaging with the member and families to determine their goals and needs.
- We use a care planning process that empowers HCBS members and caregivers with services and supports that are timely, appropriate, medically necessary, and cost-effective, including high-quality health care services.
- We use a CES tool to offer service options that are cost-effective, member-centered, and effective.
- We monitor the Care Plan on a regular basis to verify that it is adequately meeting the member's needs.
- We encourage members to live in the least-restrictive settings possible, in accordance with their personal preferences.
- Member assessment and reassessment using the InterRAI suite of tools and our comprehensive care planning promote continuity of care when the member's needs change.
- LTSS Care Management staff actively work with local housing authorities and the MFP Liaison to coordinate subsidized housing resources that are specifically targeted for eligible LTSS members.

Our approach drives quality-based outcomes for our members. These include improved or maintained functional status; enhanced quality of life; increased member satisfaction; increased adherence to the Care Plan; improved member safety; and to the extent possible, increased member self-direction.

OUR HCBS PERSON-CENTERED PLANNING AND CARE MANAGEMENT

Listen, Respect, and Act with Insight, Understanding, Compassion

Our Case Managers will collaborate with individual members to assess their needs and determine the specific services and supports that will meet these needs so they can to continue living at home. The most successful Care Plans are the ones members are committed to and believe in.

Our person-centered planning process will use a strengths-based approach to identify services and supports from natural and paid providers and community organizations. The member and family will select services within budget that help the member to attain his/her goals and support the member's highest level of self-sufficiency. Our experience in multiple states will enable us to meet Iowa's requirements that for all members enrolled in a 1915(c) HCBS waiver. We will be responsible for:

- The comprehensive needs assessment
- Care plan development

- Care coordination
- Authorization and initiation of waiver services
- Monitoring of service quality
- Supporting members in the Consumer Choices Option

For members living in the community or seeking to move to a less-restrictive setting, we will use a functional assessment to help determine support needs. With approval from the Agency, we will use our HCBS Needs Tool to assist in identification of HCBS needs to drive the determination of services and associated hours for the member's care and Care Plan.

The tool enables us to identify options for the type of services and hours required to meet the member's needs. This assessment is in addition to the InterRAI, SIS, and other condition-specific tools. The functional assessment is an evaluation of the member's ability to perform the following tasks:

- Appropriate hygiene
- Perform dressing tasks
- Prepare meals
- Mobility
- Eating and feeding
- Shop for groceries
- Laundry
- Housekeeping
- Toileting
- Transferring

Our Values: We support the member's right to self-determination and to live in a safe environment that is the least restrictive possible in accordance with personal preference. This transformative process offers members who are currently living in institutions greater control over their care and provides support for community living. Our values-driven process approach is outlined in Table 4-5.

Table 4-5: Aetna Better Health values-driven process

Component	Values-driven process
Members	Aetna Better Health puts members at the center of our support with respect for their rights of privacy, choice, and self-determination and our recognition that their individuality, dignity, and independence must be supported.
Informed decisions and choices	Case Managers provide information and guidance to assist the member and their circle of support in making informed decisions and choices.
Cost-effective service options	We offer a continuum of cost-effective service options to support the expectations and agreements established through the care planning process.
Non-medical support	Our Case Managers facilitate access to non-medical support services that are available in the community.
Advocacy	We advocate for our members and families, including others in their circle of support.
Flexibility and creativity	Aetna Better Health focuses on providing flexible and creative service delivery options.
Independent living goals	Case Managers help members identify their independent living goals and provide them with information about local resources that may provide greater self-sufficiency in housing, education, and employment.
High-quality health care	We are dedicated to providing high-quality health care services to our members, including appropriate health screening and disease prevention.
Sustainable provider partnerships	Aetna Better Health is committed to sustainable long-term partnership with our provider network to facilitate provision of the most effective, efficient, and caring services to members.

Component	Values-driven process
Community partnerships	We forge partnerships with community agencies and stakeholders who work with vulnerable members for individual and community empowerment.
Efficient use of resources	We support the efficient and cost-effective use of resources.
Member education	Our members, their families, and circles of support are educated on how to report problems with service delivery or availability.
Staff excellence	Aetna Better Health supports and values staff contributions and excellence.

PROPOSED FREQUENCY OF HCBS VISITS

We propose to contact the member at least monthly by telephone and no less than quarterly, in person, to identify any unmet needs or necessary changes. We will work with the Agency to confirm that we meet any additional requirements implemented by the State or in Iowa Code. We commit to reviewing and revising the Care Plan with the member and family:

- At least every 12 months
- When there is significant change in the member's circumstance or needs
- At the request of the member

PERSON-CENTERED SERVICE PLANNING PROCESS AND SERVICE PLAN DEVELOPMENT

Our person-centered planning process facilitates and encourages the member to exercise their ability to direct the goals in their life with the assistance of family, friends, or others in the health care community. The cornerstone of our care management model—***case formulation—includes gathering member-specific strengths, natural existing supports, and barriers to optimal health while incorporating those elements into the member's Care Plan.*** We first gather specific information from the member and the member's circle of support using a holistic approach to assessment and needs identification. Members served by HCBS are vulnerable members. We try to move at the pace set by the member. Our nurses use a conversational approach using the InterRAI tool and the techniques of motivational interviewing. This two-way conversation helps us to engage with the member and identify areas where the member wants to change.

Quality and Value through Simple, Relevant Solutions

Members can easily get overwhelmed by the number of questions, assessments, and commitments. We use a "parking lot" in our planning tool for issues that must be addressed but do not have to be resolved immediately. Our Case Managers work through "parking lot" issues in each interaction with the member but address them at a pace that works for the member.

Our information systems track HCBS and are well established and highly configurable. State and federal contractual compliance requirements are built into the system for each member enrolled in a 1915(c) waiver program. The system allows us to reassess members based on their individual needs and in accordance with the requirements of each individual waiver.

Development of the Care Plan: After confirming that the member understands the responsibilities and requirements for HCBS workers, the Case Manager and the member will collaboratively develop a Care Plan that specifies the type of services that the member requires and how the services will be provided. Case Managers meet face to face with the member and other people involved in the member's care to develop a Care Plan. To develop individualized plans of care, we:

- Collaborate with member and family to develop a plan that enhances outcomes and promotes independence
- Verify that member and family agree with and sign off on Care Plans
- Build on the strengths that member and family possess based on unmet needs, personal goals, and risk factors
- Include both formal and informal services in each Care Plan
- Assess cost-effectiveness of the services within the plan
- Supplement any care performed by a facility or alternative residential setting
- Arrange that members are maintained in the most integrated/least-restrictive setting, taking into consideration member preference and safety
- Obtain member signature and date on plan and document in electronic case record member's agreement/disagreement with the following statements:
  - I agree with the Care Plan.
  - I had the freedom to choose the services in the Care Plan.
  - I had the freedom to choose the providers of my services based on available providers.
  - I helped develop this Care Plan.
  - I am aware of my rights and responsibilities as a member of this program.
  - I am aware that the services outlined in this Care Plan are not guaranteed.
  - I have been advised of the potential risk factors outlined in this Care Plan.
  - I understand and accept these potential risk factors.

The Care Plan is based on the member's unique story. We use case formulation to synthesize information in a way that tells the story and guides care planning. Case formulation is a synthesis of the member's feelings, needs, issues and importantly, priorities. It is a root cause approach—by understanding the members' perspective, we work within the member's hierarchy of needs with the intent to improve adherence that ultimately affects sustainability of the plan.

Throughout the process, ***we encourage members to live in the least-restrictive settings possible, in accordance with their personal preferences.*** We support members in their choice of residence, whether that includes remaining in their own homes or choosing an alternative residential setting instead of an institution.

We offer choices for the member and document them: With every HCBS planning process, we discuss options for community services with the member. We will work with the member to identify service providers. We will discuss choices among providers and the process for changing providers. (If the member is in self-direction, we explain that process and how they can make choices in self-direction). We will also discuss and record options for day activities, employment, and education. If needed, we will assist the member in contacting organizations or targeted Case Managers who can assist them in additional choices for these activities.

We document alternative HCBS settings that were considered by the member. All options counseling is captured in our Case Management Information System and is a part of the member record and plan.

We involve the member's support system: Our person-centered planning process will encourage the member, their family members, and legal representatives to identify people who should participate in the care planning process as members of the ICT. Many members will also have

a target Case Manager from the community. We also respect the member's rights of privacy, choice, and self-determination and recognize that their individuality, dignity, and independence must be supported.

We convene an experienced team to support the member: We address complex needs for LTSS members through ICT, which follows a Care Team model. Once a member has designated who will be a part of the planning team, we will include that person or persons in information shared about planning and service delivery. We support the member's decisions about a main point of contact through both the planning and service authorization process. We use the provider information to contact service providers as permitted by the member and to keep them informed of the member's care needs.

We promote participation, self-determination, and informed choices: We know that most members are eager to oversee the delivery of their personal care and other services and supports. Those who need assistance may have a representative who can help them oversee care delivery. Members have a right to control the personal care services and other services and supports that significantly affect their day-to-day lives. Their independence is increased as a result of empowering them and their representatives to direct their care. In the planning process, we ***identify the member's goals for services, living situation, and caregivers.***

We inform members of their right to Iowa's Consumer Choices Option and help the member to manage the Care Plan if she or he elects that option. We offer the member choices for communicating with us, including face-to-face and Skype visits (particularly helpful for Iowa rural members) in provider offices. We schedule the time and date with the member to promote the member's participation.

We problem solve with the member: We use conflict-free care management. Case Managers authorize LTSS services based on member-specific needs. Providers never authorize services for our members. We also use a standard process model for conflict resolution. Through our person-centered planning process we strive to avoid disagreements or conflicts in the care planning process.

Stability, Competency, and Trust in the Face of Challenge

Our Case Managers are trained to use motivational interviewing to elicit information on the member's preferences and goals and to help prioritize them. When there is a disagreement about a whether a service is covered or about the level of service, we continue to discuss options with the member in attempts to reconcile the perspectives.

Our Case Managers are skilled in assisting the collaborative care planning process so that the desires of the member and the member's safety are foremost.

- **Refusal to Sign**: The member confirms their agreement with the Plan and the services by signing a copy of the Plan. We try to avoid refusals through our collaborative care planning process. If we are unable to reach a compromise after discussions with the member and caregivers, the Case Manager will document the disagreement in our Case Management Information System. If the member is not in agreement, we will inform them of their right to file a grievance. We will make it clear that services continue until the appeal is finalized. Any disagreement and appeal information is contained in the Care Plan. We will develop and implement P&Ps specific to Iowa spelling out the escalation process, including appeals and grievance process.
- **Addressing Health and Safety Issues for Members:** If the Case Manager has identified a health or safety issue but the member wants to remain in HCBS, the Case Manager will take prompt action to address and resolve the situation. For example, if the home has structural conditions that present a fall risk, the Case Manager will reach out to resources to examine whether we could make

architectural revisions to the home that would allow the member to remain there safely. Other fall risk issues, such as small rugs throughout the residence, can be addressed as the Case Manager works with the member to help them understand how they may affect their ability to move freely throughout their home.

We review Care Plans with members so that they understand: The Case Manager will review each HCBS member's Care Plan and the member's experience with services provided at least every 90 days. We also review the plan when there is a significant change or at the member or family member's request. Such changes may include physical, behavioral, or social functioning. The Case Manager also will assess the family's functioning and its ability to support the member. Changes in condition and functioning may require a change in the HCBS provided to the member. If there is a need to change any aspect of the service provision such as number of hours, type or intensity of service, or service provider, the Case Manager works with the member and member's family or caregiver to make these adjustments.

We communicate plans and updates to the member: Members always have access to their plan in our web portal as well as a hard copy in their residence. The member can request an update to the plan at any time, and are informed of this opportunity during the care planning process.

We address unique member characteristics related to culture, language, and literacy: All member presentations and materials are written using plain language. This means content is written in a clear, genuine, optimistic, and purposeful tone. Our chosen typeface will be legible and approachable. The design layout will be uncluttered and use white space effectively. Because our members' needs and cultural preferences are diverse, we tailor our words and the tone of our messaging to meet their needs. We make certain materials included on our website are compliant with the Americans with Disabilities Act (ADA) and Section 508 of the Rehabilitation Act of 1973, as amended 29 U.S.C. § 794(d). Written communications are always at a level so they are easily understood. Table 4-6 shows examples of ways we tailor our information for members with challenges.

Table 4-6: Member comprehension limitations and our solutions

Member issue	Aetna Medicaid solution
Vision impaired or difficulty in understanding written materials	Member Services reads material to member or representative Materials sent in audio format Materials sent in Braille, large-print format
Hearing difficulty	Relay services Teletypewriter/Telecommunication Device for the Deaf
Language barriers	Interpreters – foreign language and sign language Computer access real-time translation Staff experienced with mental health and developmental disabilities
Limited English proficiency	Simple language meeting Medicaid requirements for reading at six-grade level

ELEMENTS WE WILL REQUIRE IN THE PERSON-CENTERED CARE PLAN:

We have the capability to implement and document the required elements of the HCBS person-centered Care Plan. Most of these elements are captured in our standardized InterRAI assessments, and we will add others to our planning tool. In the Care Plan, we will:

- Address the full array of medical and non-medical services
- Meet the needs identified through the needs assessment
- Reflect member preference for the delivery of such services and supports
- Reflect that the setting in which the individual resides is chosen by the member
- Reflect the member's strengths and preferences, clinical and support needs
- Identify individually identified goals and desired outcomes that are observable and measurable
- Identify interventions and supports needed to meet members' goals and incremental action steps as appropriate
- Identify services and supports, both paid and unpaid; frequency of services
- Identify names of providers
- Identify activities to encourage the consumer to make choices
- Include description of any restrictions on the member's rights and a plan to restore the rights
- Identify risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed
- Be understandable to the individual (plain language; accessible to members with disabilities, cultural issues, or language barriers)
- Identify the individual or entity responsible for monitoring the plan
- Include informed consent of the member in writing and signed by all individuals and providers responsible for its implementation
- Be distributed to the member and other people involved in the plan
- Indicate if the member has elected to self-direct services

WE HELP THE MEMBER DEVELOP AN EMERGENCY PLAN [SOW 4.4.3.2]

Every Care Plan for an LTSS or HCBS member in the community includes a back-up plan (which we call a contingency plan). This also serves as the member's Emergency Plan. As a part of each assessment and reassessment process, the Case Manager works with the member and the member's supports to identify and update emergency contacts. In this plan, we anticipate and address member-specific emergencies such as a health crisis or a critical service gap. The back-up plan includes specific steps that the member should take, ranging from calling the service provider to calling for emergency assistance. The plan always includes information on how to access Aetna Better Health's 24-hour assistance line and information on how to reach the Case Manager. The plan includes information on safety concerns, emergency back-up support, and crisis response system identified by the interdisciplinary team (if needed). Depending on the member's needs, it may also identify contacts designated by Aetna Better Health, the HH, or the IHH providers as applicable services.

We review the plan with the member and family and keep a copy in our system. In each face-to-face visit (no less than quarterly), we verify that the member is aware of the plan and how to activate it. In case it needs to be activated, the member's plan is available in multiple locations: it is often posted on the member's refrigerator; is available to caregivers and providers; it is also available on our app and on the member website. In addition to care management staff, Aetna Better Health's Member Services staff also have access to the plan. These staff members can provide instructions on what to do if a caregiver does not show up. Member Services staff have criteria for authorizing emergency home health, respite care, or emergency services. Staff are trained to transfer the member to a clinician if there is a decision needed outside their matrix.

In Iowa, we also help the member develop a "disaster" plan in the event of a natural disaster such as a tornado. This plan may include evacuation planning with detailed information added to the member's case file about where the member will go, who will transport the member, and how to reach the member at the alternate location. The member and member's circle of support will have information about how to contact a Case Manager or nurse if our office is damaged and our local telephone lines are not in service. In addition, the Case Manager will share information from the Federal Emergency Management Agency's website at www.fema.gov and the state of Iowa's website, *Ready Iowa*, at WWW.BEREADY.IOWA.GOV.

Local Based Plan

The Case Manager will also encourage the member to register with the state's Emergency Preparedness Voluntary Registry at https://www13.state.us/SpecialNeeds/signin.aspx. If the member or representative is unable to register on their own, the Case Manager will assist them in completing this registration. In the event of a natural disaster such as a tornado, blizzard, or other incident, we will visit our home-bound members whom we were not able to contact by telephone as soon as it is safe to do so. During this visit, we will determine if they are safe, receiving needed care; if they need any further assistance, the Case Manager will link them to appropriate resources.

Attachment 5 – Section 4.4, Question 2

2. Submit a sample service plan.

Please see Appendix F for a sample Service and Care Plan.

Attachment 5 – Section 4.4, Question 3 [SOW 4.4.4, 4.4.5 and sub-elements]

3. Describe how member's expenditures are tracked against any aggregate monthly cost caps.

We monitor against expenditure cap

We propose a care planning process for Iowa that incorporates costs into the planning and decision-making process. We have successfully used this approach in other states to support member autonomy in making service choices while effectively managing costs according to program requirements. As we describe here, we establish a Care Plan within the monthly cost caps with the member as part of the planning process. Monthly expenditures are traced through our QNXT™ claims management system and monitored through our Care Management Information System.

While developing the Care Plan with the member, we complete a CES to assess the cost-effectiveness of the services within the plan. Information used in the HCBS cost-evaluation process includes chore/homemaker services, attendant or personal care, adult day care, and home-delivered meal services. The CES tool is a standardized process to determine and better understand the expected cost of recurring HCBS in comparison to the costs of a waiver threshold determined by the state. For HCBS Services, the CES can compare the HCBS against the waiver maximum.

The CES process enables the Care Manager and Care Team (including the member) to explore different combinations of services and align the members' preferences with the cost-effectiveness of those services. The CES is completed with each reassessment and service review. It may be recalculated any time there is a change in services; a change in medical condition; when a NF member is transitioning to a community-based setting; or a member requests a change in recurring services.

Waiver limits are addressed through our CES process. Our CES Policy and Procedure (which will be submitted to the State for approval if needed) details our program and response to findings. Recurring expenses are measured against the cap:

- Members with high CES will be reviewed for opportunities to re-evaluate different options of HCBS in efforts to meet the member's needs, in accordance with their wishes.
- HCBS that exceed 85% of HCBS waiver limits must be approved by a Case Management Supervisor or other designated Medical Management leader.
- If service costs are greater than the cap, the plan must go the ICT. An ICT may provide additional information or gain consensus in the determination of a set of services that may be appropriate for the member within the cost cap.
- If the CES exceeds 100% of the institutional or HCBS waiver rate of care, other service options and alternative residential placement may be considered if the cost is expected to remain at that level or increase. In addition, the state is notified of the member's situation.
- If expenses exceed the cap, the members are reported to the state.

Prior to Contract implementation, we will develop policies for approval by the Agency that address reporting requirements from the Agency, member's refusing transition, member's refusing to sign Care Plan, and procedures for addressing major health/safety risk or incident.

We will monitor appropriate enrollment and disenrollment risks

For members enrolled in HCBS, we will see that:

No waiver services are provided for inpatient members: Our HCBS monitoring program will provide that waiver services are not furnished to individuals who are inpatient in a hospital, NF, institution for mental diseases, or ICF/ID. We will notify the Agency if the member may become ineligible for HCBS waiver services due to an inpatient stay.

HCBS settings are appropriate: We will see that non-institutional LTSS are provided in settings that comply with the Centers for Medicare and Medicaid Services (CMS) HCBS requirements as defined in regulation.

Minimum service delivery criteria are met: The member's Care Plan identifies services needed. All LTSS members will receive services based on their individual needs. If no services requests are authorized or determined as appropriate for the member, a CM Supervisor review will be automatically triggered. Follow-up will occur based on that CM supervisor review.

Claims system and our Case Management Information System service authorization reports will also be used to monitor authorized and delivered services and will indicate when no services have been authorized or delivered. We will monitor receipt and utilization of LTSS and notify the Agency if a member has not received at least one billable unit of service under the waiver in a calendar quarter. We acknowledge that the report formatting and timeframe will be prescribed by the Agency.

All services are identified to support the member in the community: We work with members approaching the cap to identify non-waiver services that are available and appropriate, including non-paid services and natural supports. Our goal is to assist the member in remaining in the community and prevent or delay institutionalization. We first meet with the member to assess the need for alternatives and to discuss what other services may be available. If the member is approaching the monthly cap, we may also determine if additional services are available through the Aetna Better Health's Exception-to-Policy process as described in our Response to RFP Section 8.

If we cannot make a service Exception to Policy and the member can no longer have their needs safely met through a 1915(c) HCBS waiver, we will try to make a transition plan with the member to the appropriate level of service. If the member refuses to transition to a more appropriate care setting, Aetna Better Health forwards this information to the Agency. Documentation of compliance will be reported to the Agency.

Notify the Agency of receipt of long term care: We will notify the Agency if a 1915(c) HCBS waiver member receives care in a hospital, NF, or ICF/ID for 30 days in one stay for purposes other than respite care.

Attachment 5 – Section 4.4, Question 4 [SOW 4.4.7]

4. Describe proposed methods for monitoring the provision of services identified on a member's service plan.

How we monitor the provision of HCBS Services

We propose our integrated, multidimensional approach to monitoring provision of authorized HCBS. We capture monitoring data on the amount, frequency, duration, and scope of each service, in accordance with the member's service schedule documented in the Care Plan. Early notification of any concerns or issues with service provision helps us immediately identify and address any gaps in care. We propose to implement an EVV system in Iowa consistent with tools currently used by LTSS providers that minimize provider burden.

Our monitoring methods include member-focused verification, claims analysis, and auditing:

- QNXT™ captures scope and duration of services.
- Our Care Management Information System identifies gaps in preventive and other scheduled care and services.
- The care coordinator contacts the member to verify start of services within five days of the planned service start date and at least monthly thereafter for monthly service updates.
  - We use member/representative satisfaction surveys to assess their views of the care management services.
  - We collaboratively monitor any gaps in services to make certain we can implement back-up/contingency plans when appropriate.
  - We track member grievances, complaints, and CAHPS® as longer-term quality indicators to look for trends associated with service delivery and improvement opportunities.
  - We capture reporting on member authorizations and how those match the services actually provided.
- We will implement EVV in Iowa to identify immediate service gaps.

An analysis of claims payment helps us verify that services were provided. Because there is a time lag between the authorization and provision of services and the payment of claims, we audit claims data monthly and compare the data with open authorizations to address under-utilization issues. Our claims review processes determine if the member was hospitalized, admitted to a rehabilitation or detoxification facility, or was out of state.

Systemic service gaps may be an early indication that a provider is experiencing capacity issues or staffing challenges; identifying these gaps would allow the Provider Services team to be proactive and work with the provider to develop interventions in an effort to correct any impact to the provision of services to members. Interventions may include working with providers to increase staff expertise or to

find ways to add capacity. We may, in certain instances, take action against providers if we find they cannot deliver the services for which they are contracted. If we identify that we need additional providers to meet member needs, we may add additional providers to the network or work with existing providers to develop additional capacity.

We expect EVV to help improve the quality of care by helping us validate that the authorized services were actually provided onsite, on time, and by the authorized provider. As a result, we can immediately identify any gaps in care and quickly address them either through the back-up plan or as determined by the member. We currently review EVV reports associated with services reimbursement data. Features of the EVV system include:

- Ability to schedule and modify worker hours and services
- Start-time window that allows call-in within 5 to 15 minutes of scheduled time
- End time window that allows call-out within 5 to 15 minutes of scheduled time
- Real-time notices of delayed service visits and missed visits
- Use of participant telephone number (provide justification if other than the telephone of a paid staff worker)
- Use of a toll-free telephone number for calling in
- Bill generation using data recorded from the telephone system
- Security and HIPAA-compliance
- Capacity for alternate time verification arrangements when services are rendered outside the home
- Capacity for biometric identification of the person providing the services

Attachment 5 – Section 4.4, Question 5 [SOW 4.4.8 all except 4.4.8.13]

5. Describe in detail your proposed strategy for implementing the Consumer Choices Option, including how Support Broker and financial management services (FMS) will be implemented.

We will HELP members to implement The Consumer Choices Option

Three Decades of Caring for Those Most Vulnerable

We will leverage the following best practices from our other consumer choice programs to manage and support consumer-directed services for Iowa HCBS members. We will work from Iowa's baseline rate of consumer self-direction and work to increase update of the Consumer Choices Option as we have successfully done in other state Medicaid programs. Prior to Contract implementation, we will work with the Agency to confirm that our plan is consistent with all Contract requirements and Iowa Code. Our principles for these programs are that:

- Members have the best understanding of their personal care needs and other services and supports.
- Many members are competent, capable, and eager to oversee the delivery of their personal care and other services and supports.
- Members who cannot oversee the delivery of their care can assign a representative to act on their behalf.
- Members have a right to control the personal care services and other services and supports that significantly affect their day-to-day lives.
- Members' independence is increased as a result of empowering them to direct their care.

For our Iowa program, Case Managers will inform members of the choice to select Consumer Choices Options and will document the response in the care record. We work with a member to determine the appropriate level of assistance necessary to recruit, interview, and hire providers. We will use Iowa's

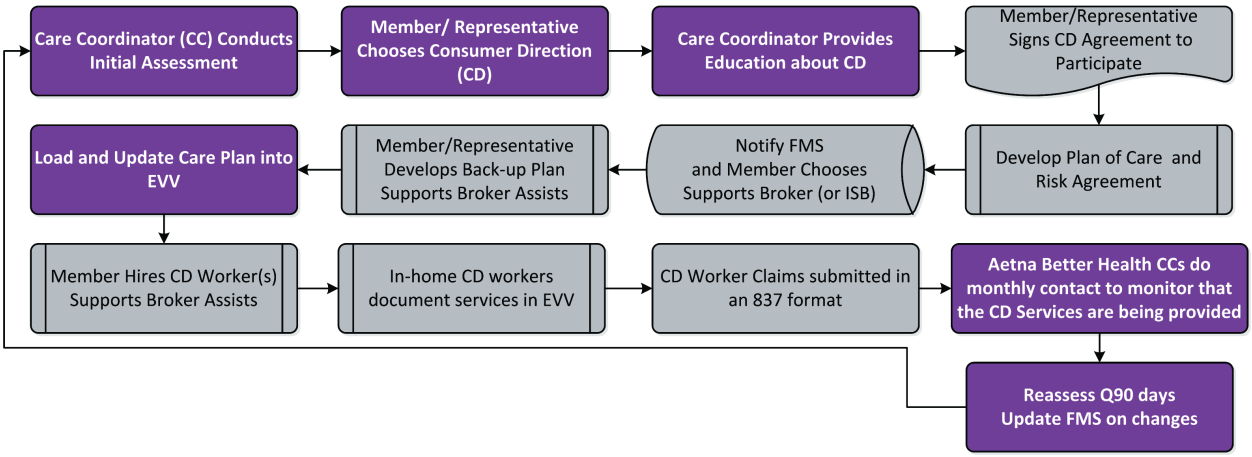
current tools for assessment, planning, and risk management if possible or will develop compliant tools for approval by the Agency. Elements of our program are:

- Identifying resources, including natural and informal supports that may assist in meeting the member's needs
- Developing a budget to address the needs of the member
- Conducting employer-related activities such as assisting a member in identifying a designated representative if needed, finding and hiring staff and providers, and completing all documentation required to pay self-directed providers
- Identifying and resolving issues related to the implementation of the budget
- Assisting the member with quality assurance activities to arrange implementation of the member's budget and utilization of the authorized budget
- Recognizing and reporting critical incidents related to self-directed services as further described in Section 10.4
- Facilitating resolution of any disputes regarding payment to providers for services rendered
- Monitoring the quality of services provided

We acknowledge that Aetna Better Health is responsible for providing all 1915(c) HCBS waiver services to members who elect the Community Choices Option using our LTSS network providers until all necessary requirements have been fulfilled to implement the self-direction of services. If the member elects not to receive services using our network providers until all necessary requirements have been fulfilled to implement the self-direction of services, we will document this decision. If the member has unmet needs while they are awaiting the completion of the community choice options, network providers or non-paid caregivers will be arranged for between the member and our Case Managers at the frequency necessary so the member's needs are met.

Figure 4-4 shows an overview of the Consumer Choices Option, which we will refine prior to Contract implementation.

Figure 4-4: Consumer Choice Option Intake Process



Experience managing consumer choices options

Aetna Medicaid provides consumer direction opportunities to the elderly and individuals with physical and intellectual disabilities who meet their state agency's criteria for an institutional LOC and who reside or will be residing in their own homes at the time services begin. Programs in Arizona, Delaware, Florida,

Illinois, Michigan, New York, and Ohio allow members to receive HCBS, including skilled nursing. These plans also contract with a Fiscal Management Intermediary to support the members in their role as caregiver employers by providing hiring packets, completing payroll, processing member and caregiver paperwork, and paying all state and federal taxes on behalf of members and caregivers.

The health plans offer members an employer authority that allows them to hire, dismiss, and supervise their caregivers. For example, in Arizona, member-hired caregivers are allowed to provide attendant care and general supervision. Attendant caregivers hired by the member are allowed to provide homemaker, personal care, and limited skilled services that can be received by members who meet specified criteria. For this skilled care, a registered nurse is required to train the member and caregivers as needed and to observe that the caregiver is providing the skilled care appropriately to the member. In Michigan and Ohio, our plans offer a budget authority model that allows for the members to receive a budget for the needed services and negotiate wages for staff.

We will prepare members to self-direct

As we work with the member and the member's caregivers to develop an HCBS Care Plan, we will inform the member of their option to self-direct services. We will explain the pros and cons of self-direction in the context of the services required by the member for safe community living. We will invite members expressing an interest in the Consumer Choices Option to complete a self-assessment using a tool approved by the Agency. Member information will be documented in our Case Management Information System. Our tool will assess:

- Member's ability to make decisions regarding their health services
- Member knowledge of available resources to access for assistance
- Member's judgement
- Member's money management skills
- Member's executive functioning skills (for managing service providers and paperwork)
- If the member wishes to assign a representative to act on their behalf for self-directed care
- Ability to manage staff including hiring, training, and terminating staff

We inform the member of risks and benefits: It is critical for the member to be fully informed of both risks and benefits, and for the member to give informed consent. Our Case Managers will meet with the member or representative before the planning process to provide education and inform the member of risks. Members entering self-direction will be required to sign an informed consent and individual risk agreement, using informed consent form and risk agreement approved by the Agency for the Consumer Choices Option.

The member representative: If a member seems to be lacking skills that predict success in self-management, we will advise the member on what it takes to successfully self-direct. We will encourage the member to voluntarily identify a representative to support them in the self-direction process. If the self-assessment results reveal that the member is unable to self-direct services but are still interested in electing the option, we will tell the member they must appoint a representative to assume the self-direction responsibilities on their behalf.

Our Case Manager will inform the member of required qualifications for representatives, assist in finding an appropriate candidate, and confirm that the member's chosen representative meets all requirements. The Case Manager will inform the members or guardians that they may change representatives at any time after reporting the change to the Case Manager. Using the representative

agreement form (Delegation of Budget Authority) available on the Agency website, the Case Manager will document the name and contact information of the chosen representative, confirmation of the individual's agreement to serve as the representative, and acceptance of the associated responsibilities. The member or the member's guardian and the representative will sign the document in the presence of the Case Manager who will attach the agreement to the member's file in our Case Management Information System and provide copies to the member, representative, and the financial management services (FMS). The Case Manager will assess the member's satisfaction with the representative at each face-to-face meeting.

Disagreement about readiness to self-direct: If during our assessment we believe the member is unable to self-direct and the member refuses to appoint a representative, the Case Manager will offer traditional Agency-based services. The Case Manager also inform the member of their right to appeal the Case Manager's decision to not allow participation in self-direction. If the member disagrees with having agency services implemented during the grievance period, the Case Manager will document the situation and complete a Care Management Risk Agreement if the refusal of Agency-based services poses a risk to the member.

Contractual requirements for support broker functions

Local Based Plan

Aetna Medicaid will delegate significant responsibility to the Consumer Choices program but will maintain an active role in assessment and oversight. We will develop comprehensive P&Ps for the program for submission to the Agency; our polices will describe in detail the interrelationship and accountabilities of independent support brokers, the Financial Management Service, Aetna Better Health, and the member. This clarity will help to establish that services are not duplicative and are well coordinated. Policies will address at minimum the following areas:

- Support broker functions
- Performance expectations for each function
- Reporting expectations
- Urgent and emergency requirements
- Back-up plan implementation if there is a gap in service
- Quality improvement and Quality Management activities
- Other areas of accountability that may be required by the Agency or NCQA

The Iowa Consumer Choices Options website currently lists more than 100 brokers from which the member may choose. We will be responsible for enrollment, ongoing training, and oversight of support brokers, using the training and program requirements already implemented by Iowa. The member will employ the support broker, but we will expect the support broker to:

- Educate members on how to use self-directed supports and services
- Review, monitor, and document progress of the member's self-directed budget
- Assist in managing budget expenditures and budget revisions
- Assist with employer functions such as recruiting, hiring, and supervising providers
- Assist with approving and processing job descriptions for direct supports
- Assist with completing forms related to staff
- Assist with approving timesheets and purchase orders or invoices for goods
- Obtain quotes for services and goods, as well as identify and negotiate with vendors

- Assist the member with problem-solving staff and vendor payment issues

We require the support broker to work collaboratively with the member to develop a budget for the self-directed services needed by the member. The budget will reflect the member's assessed needs and that the member has the flexibility to negotiate provider rates. The support broker will be required to closely monitor the adequacy and appropriateness of the services and rates to determine if adjustments are needed and to see that the member does not exceed their budget.

Our Case Managers will continue making face-to-face visits with the member based on standard member contact and face-to-face visit processes. During these visits, the Case Manager will ask the member how the self-direction is meeting his/her needs and will specifically assess issues relating to administrative functions (such as budget management, approving timesheets, and managing document filing in an accessible location).

Our FMS Contractor

Aetna Better Health commits to contracting with one or more FMS organizations to assist members choosing self-direction. Aetna Medicaid has worked with FMS organizations in other states. The FMS will be responsible for assisting the member with billing and documentation; performing payroll and employer-related duties; purchasing approved goods and services; tracking and monitoring individual budget expenditures; and identifying expenditures that are over or under budget. Our P&Ps for FMS organizations will include:

- FMS service functions
- Performance expectations for each function
- Reporting expectations
- Urgent and emergency requirements
- Back-up plan implementation if there is a gap in service
- Oversight and identification of potential fraud, waste, and abuse
- Quality improvement and Quality Management activities
- Other areas of accountability that may be required by the Agency or NCQA
- Verification of credentials for individual providers

We will contractually require the FMS entities to:

- Verify that potential providers meet all applicable qualifications prior to delivering services. Applicable qualifications include compliance with criminal record checks and adult and child abuse registry information.
- Secure a signed employment or vendor agreement, as appropriate, with each provider serving our member.
- Confirm that each provider meets all qualifications for that particular service.
- Update the employment agreements any time there is a change in any of the terms or conditions specified in the agreement.
- Provide a copy of each employment agreement to the member or representative and maintain a copy of the agreement in the FMS member file.
- Notify us when required documentation is complete and the agreement is in place so that we can coordinate transition from Aetna Better Health services to self-directed services.
- After service initiation, verify that the member or their representative reviews and approves timesheets of their providers to determine accuracy and appropriateness.

- Verify that the FMS is monitoring self-directed services so that they do not exceed 40 hours per week per individual provider.

Our Case Managers will collaborate with the FMS to coordinate care management functions to avoid duplication of efforts. Prior to service delivery, we will provide the FMS copies of relevant member documents such as Care Plans and representative agreements. We will monitor the quality and appropriateness of self-directed services to confirm that the member's assessed needs are being met. Aetna Medicaid will conduct audits of the FMS provider to safeguard compliance with documentation requirements. In addition, the Case Manager will ask the member for confirmation that a copy of the provider agreement has been provided to the member.

We acknowledge that providers under the Community Choices Option are not required to be network providers with Aetna Better Health and will not require Community Choices Option providers to sign a provider agreement. Nonetheless, we will require that our FMS provider carry out non-traditional credentialing process to document compliance with other requirements (such as background, child abuse, and criminal checks; service agreements; and credentials for independent support brokers). Credentialing will occur before services are provided to the member unless the services are part of the transition process. We will use Agency-supplied forms for provider checks or will submit our form for approval. In addition, we will report to the Agency as required on FMS performance and performance of our own oversight activities.

Training on self-direction

Aetna Better Health will include self-direction training on the Iowa Consumer Choices Option in our Case Manager training program. We will also require that members participate in training on consumer direction of HCBS and the role and responsibilities of each participant prior to assuming self-direction. We will review training available in Iowa to see that it meets requirements for this program. It may incorporate Iowa's current state-provided standardized training. This initial training and ongoing webinars will focus on Contract requirements specified by the Agency and FMS contracts. Minimum content training will include:

- Understanding the role of members or representatives in self-direction
- Understanding provider qualifications and required background and financial checks to be performed by the FMS
- Being an employer and managing staff
- Conducting administrative tasks such as staff evaluations and approval of time sheets and timekeeping requirements
- Selecting, scheduling, and terminating providers

The Case Manager will monitor member compliance with training requirements and will inform members that they may request additional training at any time by any mode of communications with Aetna Better Health or through their independent support broker.

Member back-up plan

Support brokers be responsible for assisting the member in developing a back-up (contingency) plan. We will require these plans to include the same information and alternatives for the member that are included in our back-up (contingency plan), discussed in our response to Attachment 5 – Section 4.4, Question 1. Brokers must:

- Submit a copy of the plan to the Aetna Better Health Case Manager and to the member
- Educate the member or representative on the back-up plan and document understanding
- Review and update the plan at least annually and when there are changes in service levels
- Participate in reporting required performance indicators on plan development, submission, and tracking use of services
- Notify members of available Aetna Better Health resources that may include assistance from Member Services or assistance identifying a PCP or other providers, including referrals to HH and IHH, our 24/7 Nurse Line, Telehealth services, and Crisis Support

We will track these requirements in our case management, claim, and verification information systems during Case Manager visits with the member.

We will monitor implementation of the back up plan as described in Section 4.4.8.7.

When the member disenrolls from self-direction

Voluntary: As we support the member in developing a self-direction plan, we keep each member informed that they can voluntarily discontinue the option at any time. We let members know that we will continue to work with them so they can remain in their current settings and have the level of support they need. We document our discussion with the member. When notified of a request to withdraw from the program, within seven days the Case Manager will develop a new service plan with the member if he or she voluntarily discontinues from self-direction. Our primary focus is to maintain needed services for the member and prevent any gaps in care. Case Managers are responsible for providing that there are no gaps in services during the transition period.

When a Case Manager identifies health or safety issues but the member wants to remain in consumer-directed services, the Case Manager will take prompt action to address and resolve the situation. If we cannot resolve a safety or health concern, we will notify the Agency.

Involuntary: Aetna Better Health will not terminate a member's use of self-direction involuntarily except as directed and authorized by the Agency. When a consumer is self-directing, we may identify instances in which we believe the member is not appropriate for self-direction. These situations include:

- If there is evidence of Medicaid fraud or misuse of funds
- If we believe there is a risk to the member's health or safety by continued self-direction of services that cannot be mitigated through available services and supports.

We will notify the Agency when this occurs, using the method approved by the Agency, and will submit documentation regarding the rationale for termination along with any other information we have collected. If the Agency determines that the member should be disenrolled, we will notify the member within two business days of the Agency's providing the decision to us or in accordance with Agency policy and procedures, whichever is sooner. Disenrollment from the Community Choices Option will trigger a face-to-face meeting by the Case Manager with the member, representatives, and other designated participants. We will use this meeting to review services needed so there are no interruptions or gaps in service delivery. If authorized, we will follow up with involuntary termination procedures.

Attachment 5 – Section 4.4, Question 6

6. Provide a sample of the following tools and forms related to the Consumer Choices Option:
   a. Self-assessment tool for members seeking to self-direct service;
   b. Informed consent contract; and
   c. Risk agreement.

We will use or adapt Iowa's tools and forms for the Consumer Choices Option. See Appendix G.

Attachment 5 – Section 4.4, Question 7

7. Describe your approach for monitoring the quality of service delivery and the health, safety and welfare of members participating in the Consumer Choices Option.

We maximize member independence while monitoring for safety

Aetna Better Health will frequently monitor quality of services provided to members in the Consumer Choices Option using both remote and direct care strategies. Through our contracts with the FMS, we will monitor volume, scope, and cost of services. Sources of information will include:

- Observations from our face-to-face visits and other member contact
- Reports or alerts from service providers
- Clinical provider reports including PCP or specialist contacts
- Routine and urgent reports from the support broker and FMS organization (the Case Manager will not contact the support broker directly unless requested by the member)
- Claims data showing any increases in the number of clinical visits, inpatient admissions, crisis services, or ED use
- Member reports, where the member or his or her representatives asked about experience or problems
- Required reporting from the FMS provider

We will continue to provide wraparound care management services for the member, which includes telephone and quarterly face-to-face visits. The Aetna Medicaid Case Manager is accountable for reviewing each member's Care Plan quarterly, or more frequently if needed, as well as responding to any indicators of a health, safety, or welfare problem or possible fraud activity. During these interactions Case Managers will update the member assessment, including results from evaluation of the health, safety, and welfare of the member.

Even with substantial support from Case Managers, the FMS, support brokers, caregivers, and service providers, not all members will be successful with the Consumer Choices Option. When contacting the member, we will assess success and the viability of the service delivery model for that member. We will train our Case Managers how to recognize these situations.

If the Case Manager identifies a health or safety issue, he or she will discuss the concerns with the member, initiate a member self-assessment, and collaborate to develop appropriate service alternatives. If the member chooses to disenroll from self-direction or is required to disenroll by the Agency, Case Manager can assist in safely transitioning the member to a provider agency for service delivery.

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Section 5: Billing and Collections

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SECTION 5 – BILLING AND COLLECTIONS

The table below outlines how the Scope of Work provided in RFP Attachment 1 relates to the responses to the questions provided in RFP Attachment 5. We provide this table to reduce redundancy of responses and information and to simplify the evaluation process.

For requirements in Attachment 1 that do not require a detailed response, the table below indicates our intent to comply with the stated requirement in lieu of repeating the RFP question and including a will comply statement within the body of the narrative.

Attachment 1 Requirement	Cross Reference to Attachment 5	Will Comply
5.1.1 Aggregate Cost Sharing Limit	Attachment 5 – Section 5.1, Question 1	Yes
5.1.2 Public Notice	Attachment 5 – Section 5.1, Question 2	Yes
5.2 Healthy Behaviors Program	--	Yes
5.3 Copayments	Attachment 5 – Section 5.3, Question 1	Yes
5.3.1 Exempt Populations	Attachment 5 – Section 5.3, Question 2	Yes
5.3.1.1	Attachment 5 – Section 5.3, Question 2	Yes
5.3.1.2	Attachment 5 – Section 5.3, Question 2	Yes
5.3.1.3	Attachment 5 – Section 5.3, Question 2	Yes
5.3.1.4	Attachment 5 – Section 5.3, Question 2	Yes
5.3.1.5	Attachment 5 – Section 5.3, Question 2	Yes
5.3.1.6	Attachment 5 – Section 5.3, Question 2	Yes
5.3.1.7	Attachment 5 – Section 5.3, Question 2	Yes
5.3.1.8	Attachment 5 – Section 5.3, Question 2	Yes
5.3.1.9	Attachment 5 – Section 5.3, Question 2	Yes
5.3.1.10	Attachment 5 – Section 5.3, Question 2	Yes
5.3.2 Exempt Services	Attachment 5 – Section 5.3, Question 2	Yes
5.3.4 Non-emergency Use of Emergency Department (ED)	Attachment 5 – Section 5.3, Question 2	Yes
5.3.4.1	Attachment 5 – Section 5.3, Question 2	Yes
5.3.4.2	Attachment 5 – Section 5.3, Question 2	Yes
5.3.4.3	Attachment 5 – Section 5.3, Question 2	Yes
5.3.4.4	Attachment 5 – Section 5.3, Question 2	Yes
5.3.5 Inability to Pay	Attachment 5 – Section 5.3, Question 2	Yes
5.3.6 Claims Payment	Attachment 5 – Section 5.3, Question 2	Yes
5.4 Patient Liability	Attachment 5 – Section 5.4, Question 1	Yes
5.5 IDPH Sliding Scale	Attachment 5 – Section 5.5, Question 1	Yes

5.1 General Provisions

Please explain how you propose to execute Section 5 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Our experience in cost sharing and patient liability

Aetna Better Health® of Iowa Inc. (Aetna Better Health) will leverage the successful experience of Aetna Medicaid in administering member cost sharing and patient liability programs across the nation.

Aetna Medicaid has 30 years of experience administering cost sharing requirements in Medicaid programs across the country. Currently, our Kentucky health plan administers medical and pharmacy Medicaid cost sharing requirements for more than 290,000 TANF, CHIP, and ABD members.

In addition, our health plans in the following states administer patient liability for Long Term Support Services (LTSS) including assisted living facility and nursing facility services:

- Arizona
- Florida
- Illinois
- Michigan
- New Jersey
- New York
- Ohio

In these LTSS programs, Medicare pays first, then Medicaid coordinates benefits and applies patient liability to provider payments. However, if the Medicaid contract states that co-payments or deductibles cannot be applied to patient liability, the Aetna Better Health affiliate will reimburse for the service. We understand that co-payments are applied at the point of service in a provider's office. As a result, our education and support for provider's staff is necessary to comply with program requirements and maintain member satisfaction.

Our health plans have applicable experience using QNXT™, our business application and data management system, to meet cost sharing and patient liability requirements equivalent to the expectations of the Agency.

Our philosophy

We support the State's vision of a successfully transformed health care system in the Iowa Innovation Plan:

"The new, transformed health care system will be a patient-centered, value-based delivery system that makes Iowans healthier, and supports Iowans in actively participating in their care, for both maintenance and improvement of their health."

We recognize the importance of the themes of accountability and transparency in the Medicaid program to achieve this vision. ***We will administer all cost sharing and patient liability requirements in the Contract. We will not implement cost sharing for additional services or populations beyond the requirements in the Contract.*** We want to encourage the use of appropriate covered services by members to manage health status in support of the State's goal to improve population health.

In this response, we will summarize our approach to administering cost sharing and patient liability by defining the following:

- Our strategy to track and monitor cost sharing by member

- Processes for making information on premium and cost-sharing available to both members and providers
- Aetna Better Health will not implement co-payments on non-required populations
- Our cost sharing education for provider staff
- Process to not apply co-payments to exempt populations
- Process to not apply co-payments for exempt services
- Process to manage co-payments for non-emergency use of ED visits
- Members' inability to pay for covered services
- Claims payment adjustments for cost sharing
- Proposed methodology for administering patient liability
- Administering patient liability
- Administering patient liability
- IDPH network
- Implementation of IDPH sliding fee schedule
- IDPH is the payer of last resort
- IDPH participant billing and collection procedures

Attachment 5 – Section 5.1, Question 1 [SOW 5.1.1]

1. **Describe your strategy for ensuring total cost sharing does not exceed five percent (5%) of quarterly household income.**

Our strategy to track and monitor cost sharing by member

We will use the data received on the benefit enrollment (ANSI X12-834) file from the Iowa Medicaid Enterprise as the basis for quarterly income of the household.

We will use QNXT™, our business application and data management system, as the primary tool to track and monitor cost sharing. QNXT™ is at the center of Aetna Medicaid's application architecture.

We will track members' cost sharing to determine if the five % (5%) quarterly limit is reached. Once the member reaches the 5% threshold, then cost sharing will no longer be collected until the beginning of a new quarter. When the 5% threshold is reached for a member, we will not deduct co-payment amounts from claims reimbursement for the member.

In QNXT™, we create individual records for each member. We will associate member records with a specific household record to track the applicable income information, based on the benefit enrollment (ANSI X12-834) file from the Agency. As a result, we can track all cost sharing incurred by all members of the household. This amount is included in the calculation to determine if the five % (5%) limit has been reached for a specific member.

We recognize that the information in a benefit enrollment (ANSI X12-834) file is based on a point in time, and the lag in information can lead to inaccuracies in cost sharing tracking. The member can dispute the amount of cost sharing. Our contracts will prohibit providers from denying care or services to any member because of the member's dispute of cost sharing amount at the date of service. If we determine that a member has overpaid co-payments, then the provider will refund the applicable amount to the member.

Attachment 5 – Section 5.1, Question 2 [SOW 5.1.2]

2. Describe processes for making information on premium and cost sharing available to both members and providers.

Processes for making information on premium and cost sharing available to both members and providers

We will offer providers and members the following information about cost sharing:

- The groups of individuals subject to the premiums and cost-sharing charges
- The consequences of nonpayment
- The cumulative cost-sharing maximums
- Appropriate ways for members to make payments for the required cost-sharing charges

We will document cost-sharing information through the following sources and make these available to members and providers:

- **Aetna Better Health member handbook** — A description of cost sharing requirements and how to contact Member Services to answer questions.
- **Enrollment collaterals** — Our collaterals will include a benefit overview summarizing benefits and any related cost sharing as appropriate. Prospective members will be able to obtain information through the website and events by the Agency.
- **Aetna Better Health secure member portal** — We will post the benefit overview to our website. Members will have the option to access their specific cost sharing and patient liability information.
- **Aetna Better Health secure provider portal** — We will share member specific cost sharing information with providers on their member panel through the secure provider portal. The portal will note that information is accurate based on the claims received and adjudicated, as there can easily be a lag in updating the cost-sharing information.
- **Member Services line** — Our members can access their cost sharing information by contacting our toll-free Member Services line.

If the Iowa Medicaid Enterprise provides member premium payment data, we will make the information available through the sources described above to our members.

5.2 Healthy Behaviors Program

Once an Iowa Health and Wellness Plan member is enrolled with the Contractor, the Contractor shall establish mechanisms to: (i) track member completion of the healthy behaviors and (ii) educate members on the importance and benefits of healthy behavior completion.

Aetna Better Health will be able to track the completion of selected healthy behaviors such as wellness visits, health risk assessments, or other identified activities through the case management care plan. We will also have the ability to track screenings and preventive visits using CPT codes in claims data.

We will use several channels to communicate and educate our members on the benefits of the program. These include the member portal, messaging on the mobile application, outreach through care management, and trained Member Services Representatives. Targeted outreach may be identified through a health risk assessment, member surveys, or provider referrals.

5.3 Copayments

Attachment 5 – Section 5.3, Question 1 [SOW 5.3]

1. Indicate if you propose to implement State Plan copayments on populations in addition to the Iowa Health and Wellness Plan and *hawk-i* members.

Aetna Better Health will not implement co-payments on non-required populations

We will not implement State Plan co-payments on other populations in addition to the Iowa Health and Wellness Plan and *hawk-i* members.

Attachment 5 – Section 5.3, Question 2 [SOW 5.3.1, 5.3.1.1, 5.3.1.2, 5.3.1.3, 5.3.1.4, 5.3.1.5, 5.3.1.6, 5.3.1.7, 5.3.1.8, 5.3.1.9, 5.3.1.10, 5.3.2, 5.3.4, 5.3.4.1, 5.3.4.2, 5.3.4.3, 5.3.4.4, 5.3.5, 5.3.6]

2. Describe how exempt populations and services as outlined in Section 5.3.1 and 5.3.2 will not be charged copayments.

Our cost sharing education for provider staff

We will communicate all exempt populations and services to providers through the provider manual and the provider portal. Our provider contracts will require providers to adhere to State cost-sharing requirements.

We understand the importance of educating provider office staff who apply co-payments at the point of service. Our provider education will emphasize that the provider cannot deny services to members based on whether they have or have not satisfied the cost-sharing requirements for a quarter.

Process to not apply co-payments to exempt populations

We will load a co-payment amount of $0 for exempt populations in QNXT™, our business application and data management system, to make certain that co-payments are not applied to these services. We will use the $0 co-payment amount in our system to adjudicate the provider's claim accurately.

Aetna Better Health will not charge co-payments to the following populations:

- Individuals between ages one (1) and eighteen (18), eligible under 42 CFR 435.118
- Individuals under age one (1), eligible under 42 CFR 435.118
- Disabled or blind individuals under age eighteen (18) eligible under 42 CFR 435.120 or 42 CFR 435.130
- Children for whom child welfare services are made available under Part B of title IV of the Social Security Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age
- Disabled children eligible for Medicaid under the Family Opportunity Act
- Pregnant women, during pregnancy and through the postpartum period that begins on the last day of pregnancy and extends through the end of the month in which the sixty (60) day period following termination of pregnancy ends
- Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs
- An individual receiving hospice care, as defined in section 1905(o) of the Social Security Act

- An Indian (as defined at 42 CFR 447.51) who is currently receiving or has ever received an item or service furnished by an Indian health care provider or through referral under contract health services
- Individuals who are receiving Medicaid by virtue of their breast or cervical cancer diagnosis under 42 CFR 435.213

Process to not apply co-payments for exempt services

We will load a co-payment amount of $0 for exempt services in QNXT™ to make certain that co-payments are not applied to these services. We use the $0 co-payment amount in our system to adjudicate the provider's claim accurately.

We will not apply co-payments for the following services in claims processing:

- Preventive services provided to children under age eighteen
- Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p) and counseling for cessation of tobacco use
- Provider preventable services as defined at 42 CFR 447.26(b)
- Family planning services and supplies described in section 1905(a)(4)(C) of the Social Security Act

Process to manage co-payments for non-emergency use of ED visits

For non-emergency use of an Emergency Department (ED), we will institute the following co-payments:

- For an Iowa Health and Wellness Plan member: $8
- For a *hawk-i* member: $25
- For *hawk-i* members whose family income is less than 150% of the federal poverty level: $0

No cost-sharing for non-emergency use of the ED can be imposed by the hospital provider until the hospital conducts an appropriate medical screening pursuant to 42 CFR 489.24 to determine the member does not need emergency services.

We will administer required co-payments for non-emergency use of ED in QNXT™. In QNXT™, we create a record for covered services. The provider coding of billing for ED services will document non-emergency services. We will monitor this through periodic chart reviews.

PROVIDER COMPLIANCE WITH STATE REQUIRED EVALUATIONS DURING ED VISITS

Our contracts with hospitals will require them to comply with State-required evaluations and communications during member ED visits. The Aetna Better Health provider manual will document the evaluation requirements during ED visits.

Before providing non-emergency treatment and imposing cost-sharing for such services on an individual, the hospital must:

- Inform the individual of the amount of his or her cost-sharing obligation for non-emergency services provided in the emergency department
- Provide the individual with the name and location of an available and accessible alternative non-emergency services provider. If geographical or other circumstances prevent the hospital from meeting this requirement, cost-sharing may not be imposed
- Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount. The assessment of access to timely services must be based on the medical needs of the member

- Provide a referral to coordinate scheduling for treatment by the alternative provider

PROVIDER COMPLIANCE WITH STATE REQUIRED COMMUNICATION TO MEMBERS DURING ED VISITS

We will require providers to comply with State required communication during member ED visits including:

Members' inability to pay for covered services

We understand that members can assert to providers that they are unable to pay the co-payment for required services. Our contracts will prohibit providers from denying care or services to any member because of the member's inability to pay the co-payment. We will take the following steps to support this policy:

- Provider education
- Documentation in the provider manual that is an extension of the provider contract
- Assistance for members who report they have been denied services for inability to pay

Claims payment adjustments for cost sharing

We will reduce reimbursement to providers by the amount of the member's co-payment obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

5.4 Patient Liability

Attachment 5 – Section 5.4, Question 1 [SOW 5.4]

1. Describe your proposed methodology for notifying providers of the patient liability amount and paying providers net of the applicable patient liability amount.

Proposed methodology for administering patient liability

Aetna Better Health understands that all patient liability amounts will be provided in the 834 file on a regular basis for all claim types and members. We update information in the system as we receive and adjudicate claims, and thus is current only as of the most recent adjudicated claims.

We recognize that the information in an 834 file is based on a point in time, and the lag in information can lead to inaccuracies in patient liability tracking. The member can dispute the amount of patient liability. Our contracts will prohibit providers from denying care or services to any member because of the member's dispute of patient liability amount at the date of service.

We will offer current information on patient liability and payment to providers net of the applicable patient liability proactively online through the Aetna Better Health online provider portal and via our toll-free Member Services line. Also, we will document the information for providers to review on a retrospective basis through electronic remittance advice/explanation of payment notices.

Compliance with patient liability requirements

We understand there are members who have a patient liability that must be met before Medicaid reimbursement for services is available. The State will determine the patient liability amount. Aetna will utilize the provider contract, provider manual, and the Aetna Better Health of Iowa website to guide providers' processes regarding patient liability. We understand patient liability applies to the following categories of members:

- Members in an institutional setting
- 1915(c) and 1915(i) members

We will have policies and procedures to administer patient liability where applicable. We will receive applicable patient liability amounts from the Iowa Medicaid Enterprise for members.

We will pay providers net of the applicable patient liability amount. We will communicate the liability amount to providers and delegate the collection of patient liability to the network providers.

We receive the patient liability amount from the benefit enrollment (ANSI X12-834) file or other state proprietary file. We load that dollar amount and the specific dates to which the amount applies. The system applies the patient liability based on the services being rendered. For example processing skilled nursing claims claims, the system will calculate the payment and then look to the patient liability table and if there are dollars showing for those dates, it will reduce the payment and attach the appropriate HIPAA remit comment.

Our provider dispute process will trigger a review of patient liability information as of the date of service of a specific claim.

AETNA BETTER HEALTH TERMS FOR PROVIDER AGREEMENTS RELATED TO PATIENT LIABILITY

We will define industry standards terms related to patient liability for use in provider communications:

- **Co-payment** — A charge required under a Plan that must be paid by a Member at the time of the provision of Covered Services, or at such other time as determined by Participating Group Provider. The co-payment is expressed as a specific dollar amount.
- **Deductible** — An amount that a Member must pay for Covered Services during a specified coverage period in accordance with the Member's Plan before benefits will be paid.
- **Member Cost Share Rates** — These rates are inclusive of any applicable Member Co-payment, Coinsurance or Deductible.

EXAMPLE OF AETNA BETTER HEALTH PROVIDER REQUIREMENTS FOR PATIENT LIABILITY

In our provider agreements, we define the terms of provider's responsibility to meet the Agency's patient liability requirements. Listed below is an example of ***our provider contract language*** related to patient liability:

"Participating Group Providers shall receive compensation solely from Group for services rendered to Members under the terms of this Agreement, and shall in no event bill Company, Government Sponsor or Members for any such services (except for any Co-payments, Coinsurance or Deductibles, if any, that Members may be required to pay for certain Covered Services).

Group may bill or charge Members only in the following circumstances: (a) applicable Co-payments, Coinsurance and/or Deductibles, if any, not collected at the time that Covered Services are rendered; and (b) for services that are not Covered Services only if: (i) the Member's Plan provides and/or Company confirms that the specific services are not covered; (ii) the Member was advised in writing prior to the services being rendered that the specific services may not be Covered Services; and (iii) the Member agreed in writing to pay for such services after being so advised. Group acknowledges that Company's denial or adjustment of payment to Group based on Company's performance of utilization management as described in Section 4.1.4 or otherwise is not a denial of Covered Services under this Agreement or under the terms of a Plan, except if Company confirms otherwise under this Section 4.3.1. Group may bill or charge individuals who were not Members at the time that services were rendered."

5.5 IDPH Sliding Scale

Attachment 5 – Section 5.5, Question 1

1. Describe how your organization will ensure the IDPH approved sliding fee schedule is implemented among network providers.

IDPH network

Aetna Better Health understands that the IDPH payment for Substance Use Disorders services is capitated, and the selected Contractor will receive a prorated amount of the annual contract for IDPH services monthly. We will submit an invoice monthly to IDPH for Substance Use Disorders services.

We also understand that IDPH will re-procure the provider network for IDPH-funded substance use disorder treatment services, to be effective in January 2016. We will reimburse IDPH Substance Use Disorders providers at or above the Medicaid fee schedule.

Implementation of IDPH sliding fee schedule

Monthly, we will receive the IDPH data for sliding fee amounts from the Iowa Medicaid Enterprise and load it into QNXT™, our business application and data management system. The member records in QNXT™ will store the cost-sharing amounts specific to each individual.

In adjudicating the claims for IDPH services, we will match member benefit information to provider reimbursement for services to determine adjustments to the provider's payment for Substance Use Disorders services based on the member's ability to pay.

IDPH is the payer of last resort

We will use QNXT™ to process provider claims with IDPH as the payer of last resort. QNXT™ has system edits in place to validate situations where members have other commercial health, casualty, workers compensation, or Medicare insurance coverage. If we discover that a member has other insurance (OI) coverage, we will document the coverage in QNXT™.

If we receive claims with an explanation of benefits (EOB) attached for covered members with documented third-party liability or other insurance coverage, we will process these claims with Aetna Better Health as the payer of last resort. The system will produce a health care claim payment/advice 835 transaction for response to the provider. Coordination of benefits will review all other payer sources for payment prior to IDPH.

IDPH participant billing and collection procedures

We will define the following IDPH participant billing and collection procedures for providers in the provider manual:

- Non-denial of services because of inability to pay
- No charge for missed appointments
- One-time no-show fee
- Amount of no-show fee to be established by IDP

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Section 6: Provider Network Requirements

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SECTION 6 – PROVIDER NETWORK REQUIREMENTS

Below is a table that outlines how the Scope of Work provided in RFP Attachment 1 relates to the responses to the questions provided in RFP Attachment 5. We provide this table to reduce redundancy of responses and information and to simplify the evaluation process for the evaluators.

For requirements in Attachment 1 that do not require a detailed response, the table below indicates our intent to comply with the stated requirement in lieu of repeating the RFP question and including a will comply statement within the body of the narrative.

Attachment 1 Requirement	Cross reference to Attachment 5	Will comply
6.1 General Provisions	Not applicable: Header only	Yes
6.1.1 Provider Network	Attachment 5 – Section 6.1, Question 1, 2	Yes
6.1.2 Provider Agreements	Attachment 5 – Section 6.1.2, Questions 1,2, 4	Yes
6.1.2.1 Nursing Facility Provider Agreements	Attachment 5 – Section 6.1.2, Question 2	Yes
6.1.2.1.1	Attachment 5 – Section 6.1.2, Question 2	Yes
6.1.2.1.2	Attachment 5 – Section 6.1.2, Question 2	Yes
6.1.2.1.3	Attachment 5 – Section 6.1.2, Question 2	Yes
6.1.2.1.4	Attachment 5 – Section 6.1.2, Question 2	Yes
6.1.2.1.5	Attachment 5 – Section 6.1.2, Question 2	Yes
6.1.2.1.6	Attachment 5 – Section 6.1.2, Question 2	Yes
6.1.2.1.7	Attachment 5 – Section 6.1.2, Question 2	Yes
6.1.2.2 HCBS Providers	Attachment 5 – Section 6.1.2, Question 2	Yes
6.1.2.2.1	Attachment 5 – Section 6.1.2, Question 2	Yes
6.1.2.2.2	Attachment 5 – Section 6.1.2, Question 2	Yes
6.1.2.2.3	Attachment 5 – Section 6.1.2, Question 2	Yes
6.1.2.2.4	Attachment 5 – Section 6.1.2, Question 2	Yes
6.1.2.2.5	Attachment 5 – Section 6.1.2, Question 2	Yes
6.1.3 Provider Credentialing	Attachment 5 – Section 6.1.3, Question 1	Yes
6.1.3.1 Credentialing Policies and Procedures	Attachment 5 – Section 6.1.3, Question 1	Yes
6.1.3.2 Adverse Actions Taken on Provider Applications for Program Integrity Reasons	Attachment 5 – Section 6.1.3, Question 3	Yes
6.1.3.3 Timeliness	Attachment 5 – Section 6.1.3, Question 1	Yes
6.1.3.4 LTSS Providers	Attachment 5 – Section 6.1.3, Question 4	Yes
6.1.3.5 Facility Requirements	--	Yes
6.1.3.6 Substance Abuse Providers	--	Yes
6.1.3.7 Non-Licensed Providers	Attachment 5 – Section 6.1.3, Question 4	Yes
6.1.4 Cultural Competence	Attachment 5 – Section 6.1.4, Question 1	Yes

Attachment 1 Requirement	Cross reference to Attachment 5	Will comply
6.1.4.1 Culturally Appropriate Care.	Attachment 5 – Section 6.1.4, Question 1	Yes
6.1.5 Provider-Patient Relationship	--	Yes
6.1.6 Provider Relations and Communications	Attachment 5 – Section 6.1.6, Question 1	Yes
6.1.6.1 Provider Manual	Attachment 5 – Section 6.1.6, Question 2	Yes
6.1.6.1.1	Attachment 5 – Section 6.1.6, Question 2	Yes
6.1.6.1.2	Attachment 5 – Section 6.1.6, Question 2	Yes
6.1.6.1.3	Attachment 5 – Section 6.1.6, Question 2	Yes
6.1.6.1.4	Attachment 5 – Section 6.1.6, Question 2	Yes
6.1.6.1.5	Attachment 5 – Section 6.1.6, Question 2	Yes
6.1.6.1.6	Attachment 5 – Section 6.1.6, Question 2	Yes
6.1.6.1.7	Attachment 5 – Section 6.1.6, Question 2	Yes
6.1.6.1.8	Attachment 5 – Section 6.1.6, Question 2	Yes
6.1.6.1.9	Attachment 5 – Section 6.1.6, Question 2	Yes
6.1.6.1.10	Attachment 5 – Section 6.1.6, Question 2	Yes
6.1.6.1.11	Attachment 5 – Section 6.1.6, Question 2	Yes
6.1.6.2 Provider Website	Attachment 5 – Section 6.1.6, Question 3	Yes
6.1.6.3 Provider Services Helpline	Attachment 5 – Section 6.1.6, Question 4	Yes
6.1.6.4 Provider Training.	Attachment 5 – Section 6.1.6, Question 5	Yes
6.1.6.4.1	Attachment 5 – Section 6.1.6, Question 5	Yes
6.1.6.4.2	Attachment 5 – Section 6.1.6, Question 5	Yes
6.1.6.4.3	Attachment 5 – Section 6.1.6, Question 5	Yes
6.1.6.4.4	Attachment 5 – Section 6.1.6, Question 5	Yes
6.1.6.4.5	Attachment 5 – Section 6.1.6, Question 5	Yes
6.1.6.4.6	Attachment 5 – Section 6.1.6, Question 5	Yes
6.1.6.4.7	Attachment 5 – Section 6.1.6, Question 5	Yes
6.1.6.4.8	Attachment 5 – Section 6.1.6, Question 5	Yes
6.1.6.5 Communication Review and Approval	Attachment 5 – Section 6.1.6, Question 2	Yes
6.1.6.6 State Sponsored Activities		Yes
6.1.7 Contractor Developed Materials	--	Yes
6.1.8 Notification of Provider Disenrollment	Attachment 5 – Section 6.1.8, Question 1	Yes
6.1.9 Medical Records	Attachment 5 – Section 6.1.9, Question 1	Yes
6.1.9.1 Maintenance and Retention	Attachment 5 – Section 6.1.9, Question 1	Yes
6.1.9.2 Member Rights	Attachment 5 – Section 6.1.9, Question 1	Yes
6.1.9.3 Access to Medical and Financial Records	--	Yes

Attachment 1 Requirement	Cross reference to Attachment 5	Will comply
6.1.9.4 Confidentiality of Medical Records	Attachment 5 – Section 6.1.9, Question 1	Yes
6.1.10 Availability of Services	Attachment 5 – Section 6.1.10, Question 1	Yes
6.1.11 Provider Compliance	Attachment 5 – Section 6.1.11, Questions 1, 2	Yes
6.2 Network Development and Adequacy	Not applicable: header only	Yes
6.2.1 Member Choice	Attachment 5 – Section 6.2, Question 1	Yes
6.2.2 Network Development and Maintenance	Attachment 5 – Section 6.2, Question 1	Yes
6.2.2.1	Attachment 5 – Section 6.2, Question 1	Yes
6.2.2.2	Attachment 5 – Section 6.2, Question 1	Yes
6.2.2.3	Attachment 5 – Section 6.2, Question 1	Yes
6.2.2.4	Attachment 5 – Section 6.2, Question 1	Yes
6.2.2.5	Attachment 5 – Section 6.2, Question 1	Yes
6.2.2.6	Attachment 5 – Section 6.2, Question 1	Yes
6.2.2.7	Attachment 5 – Section 6.2, Question 1	Yes
6.2.3 Network Adequacy	Attachment 5 – Section 6.2, Question 1	Yes
6.2.3.1 Rural Considerations	Attachment 5 – Section 6.2, Question 2	Yes
6.2.4 Out of Network Providers	Attachment 5 – Section 6.2, Question 3	Yes
6.2.4.1 Out of Network Care for Duals	Attachment 5 – Section 6.2, Question 3	Yes
6.2.4.1.1	Attachment 5 – Section 6.2, Question 3	Yes
6.2.4.1.2	Attachment 5 – Section 6.2, Question 3	Yes
6.2.4.1.3	Attachment 5 – Section 6.2, Question 3	Yes
6.3 Requirements by Provider Type	Not applicable: header only	Yes
6.3.1 Primary Care Providers	Attachment 5 – Section 6.3, Questions 1, 2, 3	Yes
6.3.2 Physician Extenders	Attachment 5 – Section 6.3, Question 4	Yes
6.3.3 Behavioral Health Providers	Attachment 5 – Section 6.3, Question 4	Yes
6.3.4 Essential Hospital Services	Attachment 5 – Section 6.3, Question 4	Yes
6.3.5 Physician Specialists	Attachment 5 – Section 6.3, Question 4	Yes
6.3.6 Health Homes	Attachment 5 – Section 6.3, Question 4	Yes
6.3.7 Federally Qualified Health Centers and Rural Health Clinics	Attachment 5 – Section 6.3, Question 4	Yes
6.3.8 Family Planning Clinics	Attachment 5 – Section 6.3, Question 4	Yes
6.3.9 Maternal and Child Health Centers	Attachment 5 – Section 6.3, Question 4	Yes
6.3.10 Urgent Care Clinics	Attachment 5 – Section 6.3, Question 4	Yes
6.3.11 Other Safety Net Providers and Community Partners	Attachment 5 – Section 6.3, Question 4	Yes
6.3.12 Community-Based Residential Alternatives	Attachment 5 – Section 6.3, Question 4	Yes

Attachment 1 Requirement	Cross reference to Attachment 5	Will comply
6.3.13 Indian Healthcare Providers	Attachment 5 – Section 6.3, Question 5	Yes
6.3.13.1	Attachment 5 – Section 6.3, Question 5	Yes
6.3.13.2	Attachment 5 – Section 6.3, Question 5	Yes
6.3.13.3	Attachment 5 – Section 6.3, Question 5	Yes
6.3.13.4	Attachment 5 – Section 6.3, Question 5	Yes
6.3.13.5	Attachment 5 – Section 6.3, Question 5	Yes
6.3.13.6	Attachment 5 – Section 6.3, Question 5	Yes

6.1 General provisions

Please explain how you propose to execute Section 6 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Building effective provider networks requires trust

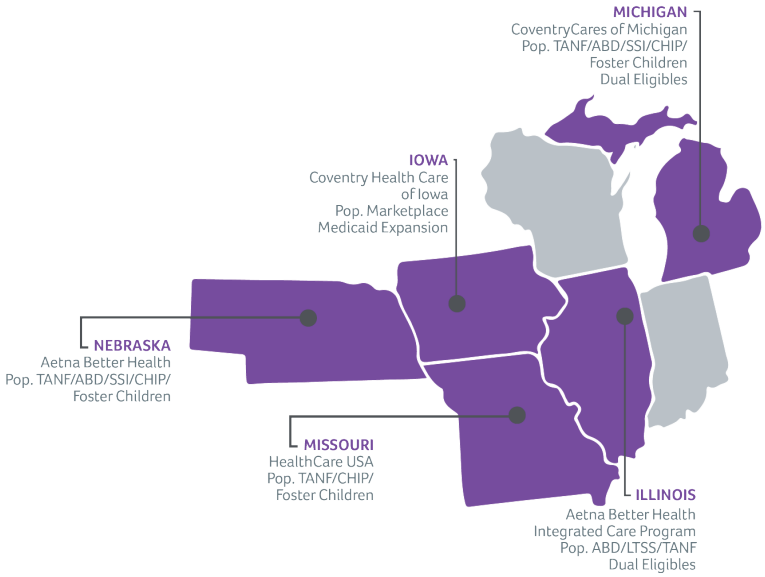
Three Decades of Caring for Those Most Vulnerable

Our parent organization (Aetna Inc.) has been operating in Iowa since 1985, and our commercial and Medicare plan (Coventry Health Care of Iowa) in Iowa today serves over 178,000 members including over 10,000 members who are eligible for Medicaid. Our existing commercial and Medicare network in Iowa has 20,304 physicians (Primary Care Providers and specialists), and over 4,000 facilities (hospitals, ambulatory surgical centers, skilled nursing facilities, radiology centers, etc.). We are not new to the state – rather, we have institutional knowledge about Iowa that we will leverage as we create our provider network for the State. Because of Aetna Medicaid's decades of experience in contracting provider networks in rural areas, we understand the access challenges facing Iowa.

Explore Ideas to Make the World a Better Place

This gives us an advantage in developing a strong Medicaid network. Our health plans in the contiguous states of Illinois, Missouri, Michigan and Nebraska have multi-year Medicaid managed care contracts; this will benefit Iowa in two ways: (1) providing additional out of state access to our contracted providers in rare instances when no Iowa provider is easily accessible; (2) allowing us to leverage their extensive experience in understanding needs for provider network development in rural areas.

Figure 6-1: Our health plans in the contiguous states of Illinois, Missouri, Michigan and Nebraska



Iowa is home to more than 32,300 active Medicaid providers; these are critical to providing reliable and timely care for beneficiaries across the state. Over the last several months, we have crisscrossed the state to meet providers and to understand their expectations, member needs, and where we can strengthen the network.

As we criss-crossed the State, introducing ourselves, sharing our philosophy and listening to issues and concerns about managed care, we made a deliberate decision not to ask for letters of support from people we had just met. Even though these letters were often offered and, in some cases, sent to our corporate headquarters unsolicited, we chose not to include them in this proposal. Why? Because we believe that trust is something that is earned through action and over time. We are confident we will earn the trust, and support, of Iowa providers and stakeholders but also know that it takes more than asking for a signed letter to do so. The map (Figure 6-2) on the following page illustrates just a small sample of the providers with whom we have met and tells the Aetna Medicaid story of the time and resources we already begun to commit to the State of Iowa and that will evolve throughout the lifecycle of our managed care contract.

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Figure 6-2: [redacted] **- CONFIDENTIAL**

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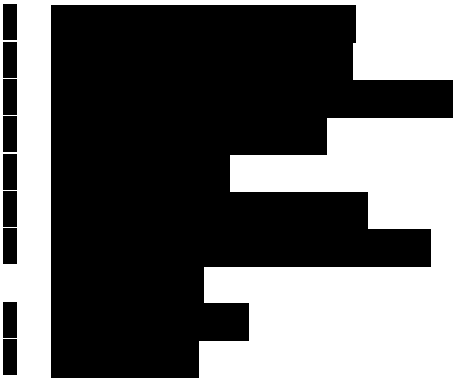
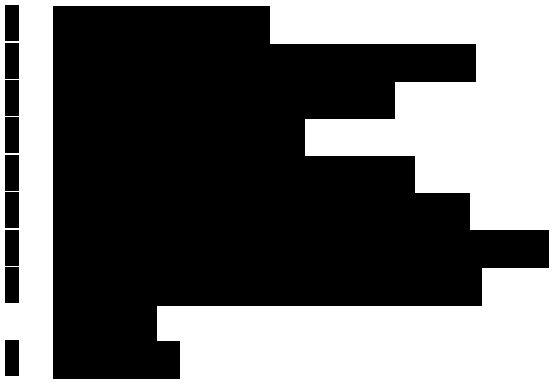
Local Based Plan

Our primary goal during these visits was to understand the clinical, behavioral, cultural, and social needs of our members, their current providers, existing provider referral patterns, and any additional supports that communities may need. By considering these essential elements, we will design a provider network that meets or exceeds member, provider, and state expectations. The major health systems, key provider groups, and stakeholders we have met with include: **- CONFIDENTIAL**





Our efforts to build relationships with Iowa providers and stakeholders have proved to be invaluable. We have learned about the unique health care challenges facing the Iowa population and have been presented with exciting opportunities to be on the forefront of health care transformation.

The statewide network and years of experience of our Coventry Cares of Iowa plan, combined with the more recent outreach meetings by our Aetna Medicaid team, has helped us identify gaps in local coverage. These gaps, and our plans to address them, are:

- **Transportation** – Getting members to providers remains a concern across Iowa. We have a statewide transportation plan to improve access to care.
- **OB/GYN Access** – From the Iowa Primary Care Association and the Iowa Medical Society, we learned that there is a shortage of OB/GYNs in Iowa. We will work to recruit family practice providers, Registered Nurse Practitioners, and Certified Nurse Midwives to supplement the pool of providers that can provide this type of service to members.
- **Access to All Rural Health Providers** – Through our nearly 30 years of experience in Medicaid-managed care, we have developed a complete understanding of the rural health delivery system and will extend contracts to each of these provider types. Work will start with identification of primary care providers, FQHCs and Rural Health Clinics (RHCs), and other safety net providers to get a clear understanding of the referral patterns for their community. We will also align with providers that specifically focus on rural areas to include:
  - 56 rural hospitals that are serving as public health agencies
  - 152 RHCs
  - 18 regional and affiliate agricultural safety clinics
  - 14 FQHC providers (representing 91 sites)
  - Community health providers
  - Indian health care providers

- **Appointments with pediatric subspecialists** – Our contracted telemedicine contractors will help expand the reach of these subspecialties and make them available to more members. We will also collaborate with the [redacted] **- CONFIDENTIAL**
- **Cultural sensitivities** – We will contact eligible migrant workers in the rural areas to confirm they understand how to access care; we will also work with Indian Health Services to provide understanding of access and coordination to care.
- **Health care for migrant workers and rural farmers** – We will develop alliances with Iowa AgriSafe Clinics and non-profit organizations such as Proteus that focus on occupational safety, wellness, and education on injuries and diseases that are prevalent for the farming community.

In addition to these six overarching issues, we are also developing our network to address the take-aways gained in meetings with the following key stakeholders:

- **Iowa Behavioral Health Association** – This association's response to our Behavioral Health Integration presentation was positive. They are encouraged by the fact that, through our commercial presence in Iowa, we have an extensive behavioral health network in place that we can draw from for our Medicaid members.
- **Association of Area Agencies on Aging** – We learned that, despite the fact that 93% of Iowans aged 50+ wish to live in their own homes as they age, too many Iowans live in nursing facilities when they could be living at home. To help address this problem, we will contract with these agencies for services to include assessments, home health (personal care, attendant care, home making, etc.), food preparation and delivery, and transportation.
- **Iowa Association of Community Providers** – This association stressed billing and reporting concerns, the importance of provider orientations, and the preference toward using a "town hall" approach for provider contracting. As detailed in the narrative that follows, our contracting, training, and billing practices will be designed to address these issues.
- **Iowa Disability and Aging Advocates Network** – They want a seamless service system where physical, behavioral health, and social services are integrated. We learned that it is essential for MCOs to designate a point person to facilitate navigation of these services for agencies. As we develop our provider network and care coordination program, we are keeping these needs central to our focus.
- **Iowa Primary Care Association** – We learned that many RHCs do not have a Patient-Centered Medical Home (PCMH) due to limited resources and will work with them to expand PCMHs. We intend to collaborate and enter into value based incentives with the 13 FQHCs, which include 30 locations, to meet our mutual goals with the State, providers, and members.

We are prepared and equipped to build, manage, monitor, and maintain a fully compliant provider network that will address the challenges voiced by these stakeholders while improving overall access to care and reducing cost.

In 2014, in Louisiana, we built a statewide provider network in nine weeks with 8500 providers in anticipation of supporting up to 250,000 members.

The following sections summarize how we will:

- Develop a provider network that meets or exceeds all of the Agency's composition requirements
- Mitigate gaps in care in rural areas and where there are under-represented or unrepresented provider types

- Cultivate productive and sustainable relationships with providers starting at the contracting stage, progressing during provider orientation, training and continuing education efforts, and maintained through proactive and supportive provider services and communications
- Offer an extensive and unique value-based provider incentive plan that will improve the cost-efficiency of delivered care while concurrently improving the quality of that care
- Implement an efficient and effective credentialing and re-credentialing process for traditional and non-traditional providers
- Make certain that our service delivery is culturally competent and focuses on reducing health care disparities and improving health literacy
- Prioritize continuity of care and seamless integrated care coordination for members
- Smooth the transition to managed services for Long Term Services and Supports (LTSS) providers through assistance with features such as information technology, billing, and systems operations
- Consistently uphold access requirements and appointment standards
- Provide members with their choice of providers to meet their cultural preferences

Attachment 5 – Section 6.1, Question 1 [SOW 6.1.1]

Describe how you plan to meet all network composition requirements.

Meeting or exceeding network composition requirements

Aetna Better Health of Iowa Inc.'s (Aetna Better Health's) strategy to meet all network composition requirements includes the following five elements:

1. **Focusing the network build** on areas with a high concentration of current and potential eligible members, while remaining aware of geographic time and distance requirements and normal practice patterns within rural areas of the state. Our goal is to create care opportunities that reflect member habit and preference.
2. **Integrating care focus** through our biopsychosocial model, developing competencies with providers of all types to incorporate care models that consider the whole person rather than the presenting condition
3. **Expanding availability** of PCMHs and accountable care organizations statewide, collaborating with and providing support for Iowa Health Homes and Integrated Heath Homes, and using incentives to encourage participation with each
4. **Developing action plans** and providing support to encourage positive outcomes with providers who underperform in quality or operational metrics, and removing providers from our network when they regularly fail to meet State or nationally accepted performance standards
5. **Developing a comprehensive transportation network** by working with Access2Care

Our primary network development goal is to execute an agreement with **all** current Iowa Medicaid providers; this includes all of the safety net and rural health providers. Local plan management and staff will continue to determine network needs and execute on expansion during the initial build and through the operation of the health plan by monitoring these services and contracts where necessary so that our network reflects actual utilization patterns and provider types.

To address each element of our network composition strategy for Iowa, detailed above, we are analyzing:

- The entire spectrum of licensed providers within the State

- The total number of members we will need to serve statewide
- The geographic distribution of the members served
- Age and gender of covered populations
- The accessibility of providers in the proposed network (24-hour access to covered services through a combination of extended provider office hours, urgent care, and telephonic medicine or triage)
- Number and coverage distribution of internal staff for customer service for 24-hour assistance
- The prevalent conditions of members in the Geographical Statistical Area (GSA)
- The ethnic composition of the GSA
- The cultural competencies of the available providers

Our current provider targets are based on a network foundation that has capacity for more than 180,000 members. We understand that our membership will include beneficiaries as identified in Exhibit C of the RFP. Our network will support the needs of these covered populations and will exceed the adequacy requirements to support this volume of membership. Our target list of providers with whom we intend to contract includes 327 facilities (including 13 FQHCs and 139 RHCs), 93 hospitals, 7,777 Primary Care Physicians, and 22,038 Specialists.

Below is a summary of the types of providers with whom we intend to contract:

- Tertiary facilities
- All critical access hospitals including public hospitals
- FQHCs
- Community, migrant, and rural health clinics (non-FQHC)
- Community-based organizations
- Community behavioral health centers
- Women's health care
- Family planning clinics
- Urgent care clinics
- HIV/AIDS services organizations (Ryan White Medical Providers)
- Indian health service providers
- Academic medical centers
- Tribal clinics
- Retail and minute clinics (for example, CVS, Walgreens, Wal-Mart)
- Mental health centers, local and county health departments, school-based clinics, maternal and child health clinics
- Prenatal care services
- Ancillary providers
- Non-emergency medical transportation
- Laboratory
- Behavioral health providers (including substance use disorders providers)
- LTSS, including forming collaborative relationships with advocacy groups and Consumer Choice Options

Who is accountable for network adequacy and completion? All of us.

Maintaining an excellent provider network requires constant care and monitoring. Everyone who answers a telephone in Member Services, Provider Services, Medical Management, Business Strategy, Quality Management, and Case Management is trained and empowered to resolve provider adequacy issues. Each of these departments assists our locally-based network resources with ongoing network development and monitoring.

Representatives from designated departments will meet to review reported, trending, and outlier cases to determine network adequacy and expansion needs to maintain accessible and quality service availability. These reviews will be supplemented by ongoing

communication with Provider Services, Medical Management, and the health plan's executive team and will emphasize accessibility and availability of care for disabled members and members with chronic diseases. We will analyze all services, including tertiary services, against The Agency's travel distance and after-hours requirements; this is our baseline measurement.

We will use a variety of tools to include:

- **Status of the network against standards** – GeoAccess® reports, network inventory, member demographic reports
- **Network sufficiency** – Utilization review of prevalent conditions, single case agreements, provider referral issues (availability of specialties), the Providers Gained and Lost report, and Unplanned Network Exits report
- **Indicators of member satisfaction** – Member Advisory Committee findings, Member Grievance and Complaint report, member survey results, prior authorization, and out-of-network requests
- **Indicators of provider adequacy** – Appointment availability, appointment wait times, and after-hours surveys; performance measures and corrective actions, Quality of Care Concerns report, and providers that did not meet credentialing review standards
- **Opportunities and innovation in care models** – PCMH and Accountable Care Organization report cards, Pay for Quality and provider incentive report cards, maximizing utilization of Iowa Health Homes, where appropriate
- **Policy and Procedure Changes** – New policy and procedure review, information from Interdisciplinary Care Teams and advocacy groups or our Member Councils, Quality Management

We will perform these analyses weekly during implementation and until 180 days after our operations start date. This is followed by monthly reviews for the remainder of the first year of operations and quarterly analysis thereafter. Provider Services, Member Services, and Medical Management teams are kept informed of our progress and are encouraged to work collectively to identify additional providers to contract based on member needs. Throughout the entire process, the Network Development team will work to solve known gaps in care access.

If we identify a particular specialty area that is unavailable or under-represented in our network, Contract Negotiators will contact providers in that specialty (if available within our service area) and offer to contract with them. However, a member's needs are paramount: we will authorize out-of-network care to address immediate needs and will always provide transportation. We will then recruit out-of-network providers with whom we have authorized care.

Attachment 5 – Section 6.1, Question 2 [SOW 6.1.1]

Describe any counties or areas of the state and any provider types in those areas where you anticipate facing network development challenges. Discuss your mitigation strategies.

Known network gaps and barriers to access to care

Network adequacy is in the eye of the beholder: the member. **If a member cannot access a provider, specialist, or pharmacy, then the network is not adequate for that member,** even if our network technically meets the Agency's definition of adequate.

In rural communities, transportation to providers is a barrier to access. From our meeting with the Iowa Medical Society, we know

that there is a shortage of OB/GYNs in Iowa. To address these two issues, we will recruit family practice providers, Registered Nurse Practitioners, and Certified Nurse Midwives to supplement the pool of providers who can provide this type of service to members. Our goal is to contract with all available Nurse Practitioners, who are crucial providers needed to fill the known gap for OB/GYNs. We understand that the key challenge is that Nurse Practitioners are under-represented in many rural areas.

We will proactively identify remaining gaps through information received from internal departments such as Member Services, Provider Services, Grievances and Appeals, Medical Management, and others. We also identify gaps through routine GeoAccess reports and other reports. We may also receive input from external sources about potential gaps including from providers, members, member advocacy groups, Area Agencies on Aging, community resources, and others.

Despite our efforts, a specific provider type might not join our network or may not be within a reasonable driving distance for a member. To address these situations, we have developed both short-term and long-term interventions to address deficiencies, transition care, and mitigate continuity of care issues. Table 6-1 identifies how we will address specific provider deficiencies.

Table 6-1– [redacted] **- CONFIDENTIAL**

Network deficiency	Solution
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

SHORT-TERM INTERVENTIONS TO ADDRESS DEFICIENCIES

If medically necessary covered services are unavailable through a participating provider, we will coordinate immediate access to services as follows:

- Our Medical Management team will arrange care by authorizing delivery of services by an out-of-network provider and facilitate transportation when no providers are nearby.
- If needed, our Network Management Department will negotiate a Single Case Agreement (SCA) for the service, usually with 24-48 hours. When we authorize out-of-network care, we will share information regarding the out-of-network utilization with the member's primary care providers (PCPs) to facilitate continuity of care.

We will never disrupt a member's ongoing course of treatment with an out-of-network provider. The transition to an in-network provider will occur when treatment has been completed or the member's condition is stable enough to allow a transfer of care. On behalf of the member, our Interdisciplinary Care Team will work with the provider to facilitate this transition.

LONG-TERM INTERVENTIONS TO ADDRESS DEFICIENCIES

Recruitment of out-of-network providers: To proactively provide consistent access to services and avoid gaps, we will recruit out-of-network providers with whom we have authorized care or executed an SCA. We will frequently assess use of out-of-network services to verify that our network contains adequate numbers and types of providers. Our Network Management Department will use this information to evaluate recruitment opportunities and identify opportunities for network improvement.

Recruitment of providers through stakeholder identification: As Aetna Medicaid has learned through work with similar populations nationwide, families and advocates have been highly successful in helping identify opportunities for network enhancement and recruiting providers participating in networks. One of our key strategies to get providers into the managed Medicaid network is to seek feedback from Aetna Medicaid-established member councils and advocacy groups. Upon recruitment, providers benefit from ongoing education, expedited credentialing, and in-office provider training.

Explore Ideas to Make the World a Better Place

Expansion of access through telehealth and telemedicine: Through a collaboration with University of Iowa, complimented by national provider Teladoc where needed, we will offer telehealth through online access to licensed professionals for episodic (acute) services and general health questions, where members can chat with a telehealth or telemedicine provider. This service is available anywhere with Internet access. We will also offer telemedicine where physicians will provide telephonic and video visits with patients and e-prescribe medications.

Crisis text line: We have an established relationship with the Crisis Text Line (CTL) for teens (http://www.crisistextline.org/get-help-now/) and are exploring ways to leverage this effort to reach the teenage population, especially in rural areas. The program uses CTL's secure platform to allow members and CTL counselors to communicate through text messaging:

1. The teen sends a text message to the CTL when in crisis: anywhere, any time.
2. A trained crisis counselor receives the text and responds quickly.

3. The crisis counselor helps the teen move from "a hot moment" (crisis) to "a cool calm" (safety) using effective active listening and suggested referrals.
4. CTL then works with the State and Aetna Better Health to link the teen member to live crisis services.

Expanded transportation: We will facilitate transportation to covered services even when there are no providers available in a nearby location.

NETWORK DEFICIENCIES: TRAVEL DISTANCES

Our goal is to eliminate deficiencies. If we identify deficiencies in member travel distance in addition to the short-term and long-term interventions identified above, we will minimize the burden of excessive travel on our members by:

- Working with providers who had previously closed their panels to determine barriers to an open panel, and provide support to create additional member access opportunities
- Collaborating with professional and advocacy associations to identify providers of all types and build relationships with them
- Consulting with Aetna's commercial and Medicare plans to identify contracted providers who are not part of our network, and meet with them to discuss Aetna Better Health's value proposition and provider support options
- Soliciting provider recommendations from internal departments and members to identify providers offering additional or specialized services
- Working with academic facilities to provide adequate access to specialty care

Three Decades of Caring for Those Most Vulnerable

Our health plans in the contiguous states of Illinois, Missouri, and Nebraska have multi-year Medicaid managed care contracts and established provider relationships in those states. In rural areas of Iowa, there may not be a provider available for the member; the closest care could be in the next state. While our preference is to contract with Iowa-based providers, we will also contract with critical providers within the contiguous states to provide continuity in care. For example, members who reside in Southwestern Iowa have a two-hour commute to Des Moines when care is not available within their own county. These members will be able to access care in the Omaha area with only a 30-minute commute. We will provide every member with transportation services to facilitate access to care. The same would be available with providers in the Quad Cities (Davenport, IA; Bettendorf, IA; Moline, IL; and Rock Island, IL) with Illinois providers.

6.1.2 Provider agreements

Attachment 5 – Section 6.1.2, Question 1 [SOW 6.1.2]

Describe your process for reviewing and authorizing all network provider contracts.

NEGOTIATING, CONTRACTING, AND COMMUNICATING WITH PROVIDERS

We view the provider contracting process as the beginning of a long-term partnership, not a one-time negotiation.

We believe that reaching agreements with providers requires collaboration and compromise. The provider contracting cycle involves initial outreach by our provider contract team, negotiations, credentialing, contract execution, and provider orientation, an area where we excel. We tailor our contracts specifically to Medicaid with dedicated staff who can talk to the providers about unique program needs. Our team will be

based in the communities they serve, fostering a higher level of responsiveness and more personal relationships.

We share Iowa's goals of promoting and sustaining the Iowa Health Homes model and moving qualified providers through our value-based services pathway towards risk-sharing model. The initial provider contracting experience plays an important role. Our local network development staff initially contacts the provider via telephone or mail to discuss the program. Staff will begin active negotiations with the provider with frequent telephone or in-person meetings as needed to achieve a participating status. During the negotiation, contracting staff will use the opportunity to provide initial education about our utilization management programs, claims filing, encounter collection, claims payment, appeals, and other aspects of managing our ongoing relationship.

Local Based Plan Our local and national provider relations' teams work closely with our legal and compliance teams to streamline the contracting process, removing unnecessary barriers to providers while staying fully compliant with state and federal regulations.

Aetna Better Health's Legal Department has already drafted our network provider contracts and submitted to the Iowa Insurance Department (IID). Through these contracts, we will set our expectations and policy requirements with all providers. If providers request changes to our proposed contracts, we will implement a three-step process:

1. For changes to the contract template language, our Provider Network Department will first refer to the annotated agreements and participation criteria guidelines outlined within the contract.
2. If the proposed changes fall outside of the annotated agreements and participation criteria guidelines, we will discuss the requested change with the Senior Network Manager and Regional Counsel to make certain that the language change proposed does not compromise our agreements with the Agency or put Aetna Better Health at increased risk.
3. If the issue is still unresolved, we will route the issue to Regional Market leadership for submission to our Contract Exceptions Review Board.

Our Contract Exceptions Review Board, comprised of senior leadership and members from each functional area, will allow Network Management to present proposed non-standard contract language or rates to multiple business areas at one time. The committee members will provide input and dialogue around non-standard requests to determine if the request will be allowed based on rational provided by the network team, in order to meet our Iowa members' specific needs. The Regional Network Head will facilitate the Contract Exceptions Review Board meeting and will be responsible for maintaining a contract exception log of decisions made by the committee.

Attachment 5 – Section 6.1.2, Question 2 [SOW 6.1.2, 6.1.2.1, 6.1.2.1.1, 6.1.2.1.2, 6.1.2.1.3, 6.1.2.1.4, 6.1.2.1.5, 6.1.2.1.6, 6.1.2.1.7, 6.1.2.2, 6.1.2.2.1, 6.1.2.2.2, 6.1.2.2.3, 6.1.2.2.4, 6.1.2.2.5]

Provide sample provider agreements.

Attached as Appendix W, are sample provider agreements for the following provider types:

- Ancillary
- Facility
- Hospital
- Physician

Aetna Better Health provider agreements submitted to the IID are pending approval.

Attachment 5 – Section 6.1.2, Question 3

Indicate if you propose to impose any requirements for exclusivity agreements for quality or payment purposes.

We will not impose any requirements for exclusivity agreements for quality or payment purposes.

Attachment 5 – Section 6.1.2, Question 4 [SOW 6.1.2] - CONFIDENTIAL

Propose the percentage of provider contracts that will be consistent with value-based purchasing by January 1, 2018 and specify the percentage annually for each year thereafter. Will you move into value-based purchasing before 2018?

[redacted]

6.1.3 Provider credentialing

Attachment 5 – Section 6.1.3, Question 1 [SOW 6.1.3, 6.1.3.1, 6.1.3.3]

Describe your credentialing process.

OUR NCQA-CERTIFIED CREDENTIALING PROCESS

We will adhere to NCQA credentialing standards. Our policies and procedures reflect all necessary requirements set by NCQA, and our credentialing program is certified by the NCQA. For example, most recently in Louisiana, we successfully built a statewide provider network with 8500 providers. Table 6-2 outlines our monitoring, evaluating, and implementing credentialing improvements strategy.

Table 6-2: Credentialing strategy

Focus	Improvement activities
Monitoring	• Monitoring provider issues. • Evaluating participating providers for re-credentialing at least every 36 months. Our selection standards include primary source verification and ongoing monitoring, tracking, and trending of quality of care and service issues by the Aetna Credentialing CVO, as well as our Quality Management Department in collaboration with Provider Services.
Evaluating	Following NCQA credentialing and re-credentialing standards.
Implementing	• Following NCQA credentialing and re-credentialing standards. • Re-credentialing participating providers at least every 36 months. We determine eligibility by the extent to which applicants meet defined requirements for education, licensure, professional standing, service availability, and accessibility, as well as for conformity to the organization's utilization and quality management requirements.

As detailed in the narrative that follows, we have developed written policies and procedures related to provider credentialing and re-credentialing that will be followed upon implementation of our contract in Iowa and employ standard methodologies for all practitioner types. These policies are designed to keep Aetna Better Health and our subcontractors in compliance with all applicable state, federal, and accrediting entity requirements.

Our process ensures that our providers are evaluated for re-credentialing every three years.

SIMPLIFIED CREDENTIALING POLICIES AND PROCEDURES MEAN LESS ADMINISTRATIVE BURDEN TO OUR PROVIDERS

Aetna Better Health will review, approve, and periodically re-certify all doctors and other licensed independent providers. We will verify the capabilities of providers interested in joining our network through our credentialing and re-credentialing process. Throughout this practice, we will educate our providers on our credentialing process, the Iowa High Quality Healthcare Initiative (the Initiative) and population, and Aetna Better Health's policies, procedures, and use of administrative tools.

Any existing traditional medical Iowa provider in the Aetna network is considered a Common Provider. We anticipate 80% of traditional medical Iowa providers to be Common Providers.

We will have a management agreement with Aetna Health Management Inc. Credentialing Verification Organization (CVO), which uses the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing DataSource. The CVO performs the credentialing process for each practitioner consistent with NCQA requirements. The CVO's credentialing process supports superior quality standards through extensive practitioner data collection, business criteria assessment, primary source verification, and enhanced data gathering. Upon receipt of a credentialing application, we will make every reasonable effort to meet State regulations timeframes.

The primary objective of our credentialing process is to make certain that all practitioners meet our rigorous criteria for participation in our network. To achieve this objective, the CVO uses a systematic process of assessing, reassessing, and validating the qualifications and practice history of a practitioner against defined participation criteria when a practitioner initially applies and thereafter during regularly scheduled intervals of the re-credentialing process. Information such as personal conduct history, malpractice history, disciplinary actions, loss or limitation of hospital privileges, active professional liability coverage, state licensure, and relevant training experience is carefully evaluated to provide quality care and to verify their good standing with regulatory and oversight organizations. We closely

review these qualifications to make certain that each practitioner meets our professional, technical, ethical and access standards. The Credentialing and Performance Committee has the authority for making final determinations for those applicants who do not meet all of our business and professional competence and conduct standards.

The CVO has a special unit that is responsible for the ongoing monitoring of state board sanctions, loss of license, and Office of Personnel Management or Office of Inspector General reporting between credentialing cycles to capture any adverse activity that would result in non-renewal or termination of licensure. These state and federal organizations are reviewed as often as the reports are made available, and processes are in place to communicate the information to the appropriate Provider Network Department or Quality Management contact for immediate action to be taken in accordance with the type of adverse action being reported.

CVO thoroughly trains and educates its staff regarding the application submission process, including credentialing, re-credentialing, and ongoing monitoring process. This will include instruction on Iowa-specific applicable reports and requirements.

OUR CREDENTIALING VERIFICATION PROCESS

We follow NCQA Standards and Guidelines for the Accreditation of Health Plans; as such, verification of primary sources may take the form of hard copy documentation, electronic or telephone report, or documented review of the latest editions or updates of cumulative reports along with periodic updates from primary sources. We require documentation of primary source information to include the source, the edition or volume used when applicable, the identification of the person(s) doing the verification, the signature or initials of the person who verified the Information, the date the information was verified, and the report date when applicable. An electronic signature or unique electronic identifier of staff may be used to document verification only if it can be demonstrated to be limited to the signatory.

Aetna confirms that a contractual relationship exists with the website agent and entitles the agent to provide verification of specified credentials on behalf of the primary source.

Our Quality Management Department will conduct medical record documentation audits of network providers. This review will include auditing for medical record criteria and documentation standards to facilitate communication and coordination and continuity of care and to promote effective and confidential patient care and quality review.

Our Medical Management Department will screen and review medical documents to identify potential adverse events as well as quality, utilization, safety, or risk issues in the care or services delivered to members. We will require any staff member who perceives a potential quality, risk management, or safety issue to refer the issue to Quality Management. A referral may originate from one of our members or in any of our departments, such as Care Management, Utilization Management, Compliance, Grievances and Appeals, or Member Services. The originating department documents the issue on a Potential Quality or Care (PQoC) investigation form and forwards it to Quality Management for evaluation. Quality Management Nurses may review and assign a different functional area within the organization to review and address the needs as indicated, such as grievances and appeals. Quality Management staff document and track PQoC issues in the PQoC business applications system.

The Chief Medical Officer or designated Medical Director will oversee the peer review investigation of these referrals and follows the quality review process, which will include:

- Concurrent or retrospective evaluation of medical records to determine the quality of the care and services provided
- Referral of potential issues to the Quality Management or Utilization Management Committee or Aetna Clinical Policy Council (CPC) for review and recommendation
- Notification to the Board of Managers indicating the decision and course of action rendered by the Aetna CPC
- Analysis of identified issues for tracking and trending
- Quarterly reporting of findings to designated committees
- Notification to the appropriate regulatory board or agency of provider contract termination, suspension, or limitations due to quality of care issues
- Development and implementation of corrective action plans as necessary
- Provision of Fair Hearing right to providers

Our subcontractors, affiliates, and providers will be required by contract to follow all RFP requirements, collect ownership information, and confirm the debarment status of all of their providers as part of their credentialing and re-credentialing process. They will be responsible for collecting ownership information, financial transactions, persons convicted of criminal activity related to federal health care programs, and confirming the debarment status of all of their providers, conducting ongoing monitoring, and reporting this information through the subcontractor and affiliate oversight process.

We will use the Ownership or Controlling Interest Disclosure, Transaction Disclosure, and Provider and Subcontractor Disclosure to provide information to the State:

- At the stage of provider credentialing and re-credentialing
- Upon execution of the provider agreement
- Within 35 days of any change in ownership of the provider
- At any time upon the request of the state agency for any or all of the information described in this section. In addition, we conduct ongoing monitoring and report this information through our annual subcontractor and affiliate oversight and audit process. If we identify an action through ongoing monitoring, we send the file for review by the Credentialing Committee.

In addition, we will conduct ongoing monitoring and report this information through our annual subcontractor and affiliate oversight and audit process. If we identify an action through ongoing monitoring, we send the file for review by the Credentialing Committee.

OUR RE-CREDENTIALING CYCLE

Aetna Better Health, in combination with CVO, uses our provider module to capture and assess provider re-credentialing information. The module contains the unique, system-generated provider ID and includes all billing and tax reporting information. It supports the contracting and credentialing processes and subsequent data, including network participation status, licensure, reimbursement schedules, billing relationships, rates, and Electronic Funds Transfer (EFT) information. This process includes:

- Re-verification of provider licenses and information on sanctions or license limitations
- Board certification if the provider was due to be recertified or indicates that board certification was obtained since the previous credentialing process
- Drug Enforcement Administration or Department of Public Safety controlled substance registration certificate, if applicable
- Current professional liability insurance coverage and updated claims history

- Sanction or restriction information from Medicare and Medicaid according to verification sources and time limits specified for the initial credentialing process
- Provider performance data review, including member pre-appeals, appeals, complaints, quality of care, and utilization management

Between re-credentialing cycles, the CVO monitors State Board sanctions, loss of license, and sanctions from the Office of Inspector General (OIG) and Office of Personnel Management (OPM).

Aetna Better Health monitors:

- Reports from the Agency
- Member pre-appeals, appeals, complaints
- Utilization review outliers
- Claims history
- Internally identified potential quality of care concerns
- Non-standard providers

ACTIONS THAT ADDRESS NONCOMPLIANCE WITH CREDENTIALING STANDARDS

Aetna Better Health will address any non-compliance with credentialing standards. Depending on the type and level of non-compliance, we may issue a Corrective Action Plan or terminate provider participation.

CREDENTIALING OTHER PROVIDER TYPES

We will conduct credentialing or re-credentialing for all providers, including advanced practice nurses and physician assistants, if listed in the provider directory. Please also see our response to RFP Attachment 5, Section 6.1.3, Question 4 for credentialing information for non-traditional and non-licensed providers.

CREDENTIALING INDIVIDUAL PROVIDERS

Individual providers who are members of a contracting group, such as an independent association or medical group, will be credentialed individually. They must complete an application, which includes a work history covering at least five years. The CVO conducts primary source verification of licensure, education, and training, evidence of graduation and specialty training, and valid DEA or DPS Controlled Substances Registration Certificate. The CVO will contact the provider's office, if applicable, to complete the application and acquire additional needed documentation. Aetna Better Health screens professional competence and conduct criteria. Before admitting a provider into our network and every three years afterward, we verify selected criteria with primary sources.

Minimum data elements required for applications for PCPs and specialists are:

- Professional license number
- Hospital where applicant has privileges and the type of privileges (initial application only)
- DEA number, when applicable
- Professional education and training (initial application only)
- Board certification
- Work history
- Malpractice insurance coverage – Name of current carrier, policy number and expiration date, and amount of coverage per occurrence and aggregate amount
- Statements from the applicant regarding:

  - Reasons for inability to perform the essential functions of the network position for which the provider is applying
  - Lack of present illegal drug use
  - History of loss of license and felony convictions
  - History of loss or limitation of privileges or disciplinary activity

- Attestation by the applicant of the correctness and completeness of the application

We will have written policies and procedures that prohibit discrimination against any provider or group of providers for participation, reimbursement, or indemnification when that provider or group of providers is acting within the scope of his or her license or certification under applicable Iowa laws or statutes, solely on the basis of that license or certification. Furthermore, if we decline to include an individual or group of providers in our network, we will give them written notice with the reasons.

CREDENTIALING FACILITY PROVIDERS

Aetna Better Health will follow current NCQA guidelines and Iowa Medical Society's Credentialing Coalition provider standards in credentialing acute care facility providers including behavioral health treatment programs. As a prerequisite for participation or continued participation, organizational providers must be in good standing with state and federal regulatory bodies, have been reviewed and approved by an accrediting body, and participate in an onsite assessment if not accredited and a CMS or State survey is not obtainable. Minimum credentialing criteria includes:

- Current, unrestricted license or certificate of occupancy, depending on State requirements
- Current accreditation or certification in all locations where services are provided by at least one of Aetna's recognized accrediting agencies, or CMS or State survey
- Good standing with Medicaid or Medicare and no OIG/OPM sanctions
- Professional liability insurance
- Advance directive policy for hospitals and long-term care acute care hospitals
- IRS W-9 required during initial credentialing

SUBCONTRACTOR CREDENTIALING AND RECREDENTIALING

As part of their credentialing and re-credentialing process, our subcontractors and affiliates must follow all of the requirements outlined in our Contract with the Agency. They must collect ownership information, confirm the debarment status of all of their providers, conduct ongoing monitoring, and report this information through the subcontractor and affiliate oversight process.

CREDENTIALING COMMUNITY-BASED SERVICE PROVIDER ORGANIZATIONS

We will verify that non-traditional community-based providers meet the minimum credentialing and licensing through the Aetna Better Health Community-based Provider Credentialing/Quality Review Committee, which includes the Chief Operating Officer, Medical Director, Quality Director, Provider Services Manager, and Credentialing Coordinator. We will credential organizational, individual, and non-traditional community-based service providers using procedures and standards appropriate to their type.

Non-traditional community-based providers we will credential at the organizational level include:

- Personal care attendants and care aids
- Non-skilled home care agencies
- Durable medical equipment and medical supplies
- Assisted living centers or homes

- Home-delivered meal providers
- Behavioral health residential and community based facilities
- Transportation providers
- Adult day health programs
- Foster care
- Assisted living homes
- Occupational therapy and physical therapy
- Emergency response systems
- Non-skilled agencies

The minimum credentialing and licensing requirements for organizational community-based providers include:

- Valid license
- IRS W-9
- Valid Certificate of Insurance Coverage – General and professional liability or self-insurance
- DEA certificate, when applicable
- Evidence of and years of work history
- Evidence of good standing in the community
- Evidence of policies and procedures (including confidentiality)
- In good standing with Medicare/Medicaid
- Declaration of any current lawsuits, judgments, arbitration, mediations, settlements which raise concerns about quality of care
- Clearly defined service description
- Ability to demonstrate required training and evidence of staff attending
- Evidence that the provider employs systems that track member information in a way that provides member-specific information
- Professional claims history
- An onsite visit to view facility for industry standards, review staff experience, and review billing records to confirm authorizations match to billed and paid services
- A written statement regarding attendant care wages, if appropriate
- Background checks for direct care and consumer directed providers

CREDENTIALING INDIVIDUAL COMMUNITY-BASED SERVICE PROVIDERS

We will credential individual community-based service providers through our agreement with our fiscal intermediary; for example, to verify that a personal care attendant is appropriate for a member under self-direction. Requirements include:

- Valid License or certification to provide service if applicable
- IRS W-9
- Evidence of work history, if applicable
- Evidence of good standing in the community as evidenced by three personal references
- Evidence the provider was not terminated from either Medicare or Medicaid or placed on the ineligible provider list
- Declaration of any current lawsuits, judgments, arbitration, mediations, settlements which raise concerns about quality of care
- Evidence that they understand and can utilize systems that track member information in a way that provides member-specific information
- Relationship with a Fiscal Intermediary (the FEA)
- Background checks for direct care workers (may be delegated to FEA)

- State assigned ID number if applicable
- Ability to demonstrate required training and evidence of attendance; typically, we will delegate this to the FEA. Training must cover an understanding of the target population; rules and regulations; reporting critical incidents; fraud, waste, and abuse; and understanding of job responsibilities, among other topics.

Attachment 5 – Section 6.1.3, Question 2 [SOW 6.1.3]

Describe methods to streamline the provider credentialing process.

REDUCING ADMINISTRATIVE BURDEN ON PROVIDERS

Committed to Health Care Transformation in Iowa

The Council for Affordable Quality Healthcare (CAQH) is an alliance of America's largest health plans and trade associations committed to strengthening the nation's relationships with both patients and practitioners. CAQH is a not-for-profit organization that assists providers in satisfying time-consuming credentialing requirements of health care organizations. One of the initiatives of CAQH is a universal credentialing data source, the Universal Provider Datasource (UPD), whereby practitioners are invited to register with GeoAccess.

Aetna was a founding member of CAQH and was involved in the initial development and implementation of the Universal Provider Datasource. To reduce the administrative burden on our providers, we will use this database to verify the provider's credential application. We will minimize the administrative burden of the application process by allowing providers to access the national application available through the CAQH to realize similar success that Aetna has seen in other markets. For example:

- More than 95% of Aetna providers are using the UPD for Initial Credentialing
- More than 95% of providers utilize the UPD for re-credentialing
- Aetna realized return on investment every year once provider utilization reached 75%
- Provider satisfaction has increased because more than 50% of providers no longer have to contact Aetna to complete the re- credentialing process
- Use of UPD has allowed Aetna to develop uniform, technology-based training sessions for providers and staff
- Electronic availability of UPD data has allowed the development of automatic data feeds for new providers into Aetna systems
- Use of UPD has allowed Aetna to automate several re-credentialing processes

Another option we will afford our Iowa provider to ease administrative burdens associated with credentialing is to utilize the Iowa Credentialing Coalition's Iowa Statewide Universal Practitioner Credentialing Application form and its Iowa Statewide Universal Practitioner Re-credentialing Application form.

We will further expedite the credentialing process for providers joining an existing group by limiting business requirements. While we will require the provider to complete the entire credentialing verification process, we can expedite the process by placing the completed application in the queue for immediate processing and flag it as priority.

Attachment 5 – Section 6.1.3, Question 3 [SOW 6.1.3.2]

Describe your plans for performing criminal history and abuse checks and assuring all network providers hold current licensure as applicable.

ONGOING MONITORING

Aetna's Credentialing Department will monitor all provider files for federal sanctions on a recurrent basis. By reviewing sanction reports, we will determine whether a provider's license has been revoked, suspended, or disciplined. We will review sanction reports during initial credentialing and every three years thereafter during re-credentialing. In addition, monthly reports will identify any new activity. We will conduct sanction report activities as follows:

- Aetna Credentialing will query the National Practitioner Data Bank, which includes any Medicare and Medicaid sanctions, during initial credentialing and as part of the re-credentialing process. The online query process will initiate upon receipt of a completed practitioner application (initial or re-credentialing).
- Aetna Credentialing will perform ongoing monitoring of State and federal sanctions on licensure during the period between initial credentialing and re-credentialing for all providers, including providers who are considered delegated for credentialing.
- Aetna Credentialing will monitor federal sanctions monthly, as published by the U.S. Government Department of Health and Human Services OIG database; OPM database; and the General Services Administration Excluded Party List System (EPLS) as available and will reconcile new exclusions or sanctions with our population of participating network providers. If Aetna Credentialing discovers either a new licensing sanction or an OIG sanction for a practitioner, they will bring the information to Aetna Credentialing. After the review, Aetna Credentialing staff will send sanction reports to the Provider Services Supervisor to review with the Medical Director who determines required action, including immediate termination. We address such disclosures at credentialing meetings and report to the State any determinations we make at those meetings.
- Every month, we will notify the State agency of any providers denied for credentialing or re-credentialing, along with an explanation for the basis for this action.

We will also monitor for providers that have failed to renew their license or certification registration, have a revoked professional license or certification; have been terminated by the state agency; or have been excluded by OIG under 42 CFR 1001.1001 or 1001.1051.

PROHIBITION AGAINST CONTRACTING WITH EXCLUDED PROVIDERS

We will not employ or contract with providers excluded from participation in federal health care programs. Please refer to the narrative in the preceding paragraphs for the monitoring processes we implement to confirm we remain compliant with this requirement. Aetna's Credentialing Department will monitor all provider files for federal sanctions. We will review sanction reports during initial credentialing and every three years thereafter during re-credentialing. In addition, monthly reports will identify any new activity, including:

- National Practitioner Data Bank, which includes any Medicare and Medicaid sanctions
- State and federal sanctions on licensure during the period between initial credentialing and re-credentialing for all providers, including providers who are considered delegated for credentialing
- Federal sanctions monthly, as published by the U.S. Department of Health and Human Services Office of Investigations database, OPM database, and the EPLS

We will notify the Agency when we learn that a network provider is debarred. Monthly, we will notify the Agency in writing with the results of our exclusion screening, including any providers denied for credentialing or re-credentialing, along with an explanation for the basis for this action.

We will require all subcontractors and delegated entities to apply the same due diligence for credentialing, re-credentialing, and monthly monitoring.

We will terminate the participation of any individual or entity found to be excluded, debarred, suspended, or terminated by a federal health care program or any other state plan, or affiliated with someone who is, or if the individual has delinquent unpaid overpayments. We also will not make payments to institutions or entities outside of the United States.

Each of our department managers will track continued licensure in good standing for their clinical staff. Staff will be responsible for maintaining the currency of their licensure in the Aetna Talent Management system. Each department manager will verify that information is up-to-date, and the system tracks for expirations and renewals.

Attachment 5 – Section 6.1.3, Question 4 [SOW 6.1.3.4, 6.1.3.7]

Describe your plans for ensuring non-licensed providers are appropriately educated, trained, qualified and competent.

CREDENTIALING NON-TRADITIONAL AND NON-LICENSED SERVICE PROVIDERS

We are developing a credentialing system to make certain that non-traditional or non-licensed providers are appropriately educated, trained, qualified, and competent. As part of this process, we will require:

- Completed Provider Credentialing Application form
- Completed and signed Provider Employment Practices Attestation
- Certificate of Accreditation from one of the following (if applicable)
- Commission of Accreditation of Rehabilitative Facilities
- Accreditation Commission for Health Care
- Joint Commission on Accreditation of HealthCare Organizations
- Community Health Accreditation Program
- National Association for Home Care or Home Care University
- Current business or professional license
- Malpractice or Liability Insurance face sheet
- Current Medicaid or Medicare numbers
- Affidavit of a completion of a criminal history background screening as required under State and federal law on each direct service provider to confirm that they do not have any disqualifying offenses as dictated by Iowa statue (any provider, employee or volunteer of the provider meeting the definition of direct service provider who has a disqualifying offense is prohibited from providing services to our health plan members)

We will make certain non-traditional community-based service providers are appropriately educated, trained, qualified, and competent according to requirements that best fit the standards of the profession in which they practice. Types of providers in this category include personal care attendants, home delivered meal providers, homemakers, home repair, vehicle adaptation, and chore services.

Because these providers often work in the person's home, many of the requirements for individual community-based service providers apply (for example, background checks).

We will endeavor to credential these providers on the organizational level when feasible; otherwise, we will credential them individually. In either case, additional requirements will apply that are specific to the type of service. These will include:

- Registered with the Board on Registrars or other public agency responsible for review and licensure of that type of provider—for example, general contractor's license for home modification contractors
- Evidence that the provider is in business to offer the services (advertising, business and tax licenses)
- At least three professional references for the services performed

The following table, Table 6-3, illustrates the documents and certification that we will require from our LTSS Home and Community Based Services providers before they may service our members.

Table 6-3: LTSS HCBS participation criteria

	Business or professional license	Liability insurance	Criminal background attestation	Medical information confidentiality policy	Accreditation certificate	Staff orientation policies or process	Staff competency policies or process	Food training and proper storage certificate	Fire and sanitation codes certificate	Food handling/ preparation permit	Proof of contractor registered by State	Equipment test process
Adult Day Center	✓	✓	✓	✓	✓	✓	✓					
Adult Family Care Home	✓	✓	✓	✓	✓	✓	✓					
Assisted Living Home or Center	✓	✓	✓	✓	✓	✓	✓					
Home Delivered Meal and Nutrition Services	✓	✓	✓					✓	✓	✓		
Home Health Agency	✓	✓	✓	✓	✓	✓	✓					
Home Modification	✓	✓	✓						✓		✓	
Homemaker Companion Agency	✓	✓	✓	✓		✓	✓					
Personal Emergency Response System (Emergency Alert)	✓	✓	✓									✓
Fiscal Intermediary (FI)	✓	✓	✓	✓	✓	✓	✓					

6.1.4 Cultural Competence

Attachment 5 – Section 6.1.4, Question 1 [SOW 6.1.4, 6.1.4.1]

Describe your plans for ensuring the delivery of services in a culturally competent manner.

We will provide truly culturally competent care and services by placing each member at the center of everything we do. To meet and exceed the requirements in Section 6.1.4, and to serve our diverse members, providers, and their communities in the best possible way, we will adopt the 2013 enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. These 15 CLAS standards build upon and expand the scope of the requirements outlined in the RFP and will act as the foundation of our framework for developing and implementing the policies, procedures, and practices that govern our delivery of care and services.

> **"Cultural competency should infuse every aspect of member interaction and care delivery at the local, community level."**
>
> **Pamela Sedmak**
> **CEO, Aetna Medicaid**

OUR COMMITMENT TO CULTURAL COMPETENCY AND HEALTH CARE EQUITY IS MORE THAN A BINDER ON A SHELF

CLAS Standard 1

Principal Standard: Provide effective, equitable, understandable, respectful, and quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs

We embrace both the spirit and letter of the Principal Standard, and we hold ourselves accountable to it. We will continue to work with both individuals and community groups to connect with members, providers, and communities in Iowa.

We will participate in Aetna Medicaid's national Health Care Equity (HCE) program. This program exemplifies our commitment to effective and equitable care and services by respecting and honoring, each member's cultural health beliefs, practices, preferred language, and socioeconomic background. This program guides our delivery of culturally sensitive services, communications, and programs.

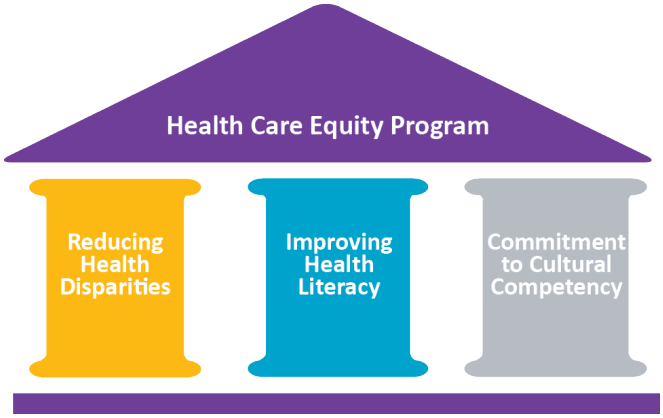
At the corporate level, Pamela Sedmak, Aetna Medicaid's Chief Executive Officer, is the executive sponsor of this comprehensive approach to ensuring culturally competent services. Alonzo White, MD, the Chief Medical Officer for Aetna Medicaid, oversees program administration for all Aetna Medicaid health plans.

CLAS Standard 9

Infuse CLAS goals, policies, and management accountability throughout the organization's planning and operations…

As illustrated by Figure 6-3, Aetna Medicaid's national HCE program focuses on the three pillars of 1) reducing health care disparities, 2) improving health literacy, and 3) strengthening our commitment to cultural competency.

Figure 6-3: The three pillars of our Health Care Equity program



In Iowa, our Quality Management Department will support the HCE program. This collaboration helps foster community involvement and direct community events that promote the alignment of HCE programs with local member needs.

CLAS Standard 2

Advance and sustain governance and leadership that promotes CLAS and health equity…

At the national strategy level, the national director of HCE will work with the our Quality Management Director and other health plan leaders to optimize allocation of resources, promote national visibility, and maintain continuity of vision and execution. With its broad authority over most every aspect of Aetna Better Health operations, our Quality Management Oversight Committee (QMOC) will serve as the governance body to verify that we stay true to HCE program goals, objectives, and programs. To establish accountability for specific HCE program elements, under the guidance of the QMOC, we will expand and develop our new Health Care Equity Committee to serve as a resource across the Aetna Better Health organization.

The HCE program provides a continuum of learning and action that includes initial, annual, and ongoing education for staff, providers, and members. It also provides opportunities for staff and community organizations to collaborate in meaningful work to reduce health care disparities for our members and promote health equity. The program combines analysis of health care data and real life member experiences to identify gaps and actions to meet the specific needs of local market populations.

A DIVERSE LEADERSHIP AND WORKFORCE TO PLAN AND DELIVER SERVICES TO OUR DIVERSE MEMBERSHIP

CLAS Standard 3

Recruit, promote, and support a diverse governance, leadership, and workforce…

We will annually assess the ability of our organization and provider network to meet the socioeconomic, cultural, and linguistic needs of our membership. We will use a variety of internal, State, and federal data sources and reporting tools to understand the changing demographics of populations enrolled in the Initiative. We will analyze year-over-year trends to anticipate changes in how we need to adjust both our staff and network provider recruitment and training programs to serve our members best. To serve our members equitably and effectively, we strive for a diverse workforce, including our leadership teams.

INCREASING CULTURAL COMPETENCY THROUGH ACTIVE LEARNING

Cultural competency and *cultural effectiveness* will infuse every aspect of care and services management for our members. The journey toward cultural competency for our staff and providers will be a continuum of learning beginning with orientation and continuing throughout the staff and provider relationships with Aetna Better Health. The HCE program's learning series will focus on HCE's three pillars, a required component of training for every new hire, as well as provider and contractor training.

CLAS Standard 4 — **Educate and train governance, leadership, and workforce in CLAS…**

Our HCE program will support ongoing cultural competency learning in several ways by:

- Requiring all staff to complete an annual Cultural Competency training course, which we refresh each year to reflect current cultural learning best practices, and which includes pre-test and post-test features to measure training effectiveness for individuals and as an organization
- Requiring all staff to complete Poverty Simulation Training
- Publishing Connect to Culture, which is a monthly all staff e-mail directing staff to the internal Culture Collaboration website for monthly cultural awareness and health care disparity education and resources
- Allocating 32 hours of paid time off annually for our staff to invest in their community through volunteer work. We encourage them to participate in hands-on projects and activities with community members to expand cultural awareness and provide real community support.

Continuous learning will encourage sharing among team members of lessons learned and best practices throughout the Aetna Better Health and Aetna Medicaid organizations.

MULTI-MEDIA APPROACH FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE MEMBER MATERIALS AND COMMUNICATION

CLAS Standard 8 — **Provide easy-to-understand print and multimedia materials and signage in the language commonly used…**

We propose a multi-media approach to our member, provider, and community communications program to meet or exceed all requirements described in the RFP. Our proposed marketing and member education materials and communications for the Iowa High Quality Healthcare Initiative will reflect our commitment to meet our members, providers, and their communities where they are.

Our proposed approach to designing, developing, and distributing member materials is based on Aetna Medicaid's national experience of what works best. Aetna Medicaid's national, long-standing experience includes implementing member-focused wellness initiatives and involving members to assume greater personal responsibility for improving their health. We will leverage this knowledge to create educational materials a with the members' needs in mind, working with members, providers, and other stakeholders. **The programs and materials we will provide will never discriminate against members based on their health history, health status, or need for health care services.**

Because our members' needs and socioeconomic backgrounds will be diverse, we will tailor our words, the tone of our messages, and any graphic representations in member materials to meet their needs, preferences, and expectations. The Center for Plain Language has recognized the efforts of our parent organization to improve the simplicity and clarity of communication. They have awarded Aetna, Inc. the top honor for their Plain Language Award for the past five years. We will provide materials on our

website that are compliant with the Americans with Disabilities Act (ADA) and Section 508 of the Rehabilitation Act of 1973, as amended 29 USC §794(d).

COLLECTING AND MAINTAINING MEMBER DEMOGRAPHICS IS KEY TO OPTIMAL SERVICE PLANNING AND DELIVERY

We will first learn about our members' service needs, preferences, and expectations through information on the enrollment roster from the Agency. We will send out new member welcome kits and follow this mailing with a welcome call and request additional information to help us serve our new member better. We specifically ask the member to share with us individual preferences for written and oral communication, and we offer the member the opportunity to self-identify by race and ethnicity.

CLAS Standard 11 — **Collect and maintain demographic data…**

We also maintain the demographic information in member reports from the State, and as described previously, review the information from our annual language needs assessments and the utilization reports from our language services vendor. We verify and update member information periodically and during each encounter.

All of this information will support our efforts to develop, implement, and measure the effectiveness of our program to provide culturally and linguistically appropriate care and services to targeted populations. More importantly, this information will be used to meet the needs and honor the preferences of every member.

SERVING MEMBERS WITH LIMITED ENGLISH PROFICIENCY

CLAS Standard 6 — **Inform individuals of the availability of language assistance…**

As further detailed in our response to RFP Attachment 5, Section 8, we will meet Contract requirements, follow established Aetna Medicaid policy and procedure, and conform to CLAS standards that address servicing members with Limited English Proficiency. Specifically we will support this commitment with our staff, providers, and subcontractors who serve our members by:

- Informing members of their right to language assistance in written materials and at every point of contact, including calls to Member Services, member materials, signage in facilities and provider offices, face-to-face meetings, and telephone communications
- Training all staff and providers to identify and respond to any member's need for language assistance services
- Supplying translation and interpreter services through vendors who employ Certified Medical Interpreters
- Reviewing language assistance vendor activity reports, and conducting our own assessments of member language preferences and service quality

CLAS Standard 5 — **Offer communication and language assistance…**

Our call center will offer a Spanish language option to route the caller directly to one of our Spanish-speaking Member Services Representatives. If a Spanish-speaking Member Services Representative is not available, or the caller requests another language, we will connect the member with Voiance®, a language services company that offers immediate interpretation for more than 200 other languages at no charge to the member. We will refer to the documented language preference in the member's record to determine how best to assist the member. We will offer sign language interpreters and provide their services for our member's provider

appointments. We will document all interpreter offers and responses, including sign language, in the business application system for future reference and for quality monitoring purposes.

These same services will be available at all provider offices, at no cost to the member. The goal of our language assistance services is to provide the same level of service to our members who may have limited English proficiency as we provide to any other member.

CLAS Standard 7 **Ensure the competence of individuals providing language assistance…**

HONORING MEMBERS' BELIEFS: SENSITIVITY TO CULTURAL DIVERSITY

Honoring our members' beliefs is integral to our approach to health care delivery for our members. A central element of our orientation for new staff will be a review and discussion of members' rights and responsibilities, including being treated with respect and dignity and recognizing and honoring a member's cultural differences. Each new hire will receive a copy of these rights and responsibilities. During quarterly walk-throughs, our Compliance Department will see that copies of these member rights are prominently displayed at each employee's desk as a reminder of their importance during our daily interactions. This approach, coupled with formal diversity training is central to maintaining an environment of diversity and inclusion.

BUILDING A CULTURE OF DIVERSITY AND INCLUSIVENESS AMONGST OUR STAFF

Aetna Inc. has been recognized nationally as an employer of choice. DiversityInc placed Aetna on the DiversityInc Top 50 Companies for Diversity list every year from 2009 through 2014. Aetna has made the list in previous years as well. The Human Rights Campaign named Aetna as one of the "Best Places to Work for lesbian, gay, bisexual and transgender (LGBT) employees" each year since this list was created in 2002.

Diversity is embedded in Aetna's culture. It is important in all aspects of our business—for our workforce, customers, suppliers, and networks of health care professionals; in our products and services; and through our contributions to the communities we serve. It is part of the Aetna way of doing business.

By leveraging all dimensions of diversity, raising awareness about the power of diversity, and demonstrating inclusive leadership, we are better positioned to understand and meet the unique needs of the people we serve across the health care system and empower them to live healthier lives.

By being inclusive, we draw out different points of view that result in stronger solutions—and true innovation. With this understanding, and with the national support of Aetna, we have developed and implemented enterprise-wide Diversity & Inclusion programs and initiatives.

Both diversity and inclusion are organizational priorities that drive business results. We achieve these results through the implementation of an integrated, comprehensive strategy, with a focus on four core areas:

1. Execution & Accountability
2. Communication & Learning
3. Brand & Business Growth
4. Talent, Culture & Engagement

Through this focused strategy, we are committed to:

- Building a diverse and inclusive workforce, focusing on recruitment, retention, development, and the advancement of talent at all levels of the organization
- Creating an inclusive workplace that encourages full engagement, so our employees can bring their full selves to work and contribute their fullest potential while achieving their individual and career goals
- Providing enterprise-wide and department-specific diversity and inclusion learning programs

"Aetna's evolution as a leader in diversity and inclusion reflects the varied needs of consumers in the changing health marketplace. By harnessing the diversity of our employees through inclusion, we consistently seek to create better, more inventive solutions that meet the unique health care needs of all different consumers. The challenge we face to continually increase the value we offer to our customers requires creativity and insight that only a diverse workforce operating in an inclusive culture can deliver."

Mark Bertolini,
Chairman and CEO, Aetna Inc.

POLICIES TO ENCOURAGE DIVERSITY AND NON-DISCRIMINATION

We will also incorporate diversity into our formal policies, administration, and delivery of services. We believe that diversity and fostering an inclusive workforce is not only the right thing to do but is also critical to maintaining a competitive advantage in today's marketplace. We embrace individual differences and the variety of perspectives and values inherent in those differences. Managing diversity involves recognizing and respecting those differences to make them a powerful resource to achieve business goals. A formal Cultural Competency training program will be mandatory for all employees. This course will focus on health literacy, regulatory requirements and expectations, and the role of culturally competent service for Medicaid health plans. In addition, we discuss the reasons for health care disparities, such as low health literacy, language differences, and member mistrust in minority and developmentally disabled populations.

CULTURAL COMPETENCY AND PROVIDERS

We recognize that our providers play an integral role in our cultural competency program. A key component of our new provider orientation will include reviewing the essential elements for delivering culturally competent care. We will provide refresher training on these elements upon request or when member grievances of other service complaints warrant. Cultural competency will be an annual topic for our provider newsletters and will be incorporated in the Aetna Better Health Provider Manual.

We will take every opportunity to be inclusive in our sourcing activities. We recognize that by integrating Traditionally Underutilized (TUU) suppliers into our supply chain, we gain access to suppliers who provide greater flexibility and speed to market. It is both Aetna's and our policy to provide TUU suppliers the maximum practicable occasion to participate in procurement opportunities. This policy encourages increased participation of TUU suppliers when soliciting bids, request for proposals or quotes, and the direct purchase of goods and services. Additionally, we will make every effort to work with non-TUU primary suppliers to encourage their use of TUU subcontractors.

The Supplier Diversity program will play an important role in our ability to successfully compete for and win business. We value the innovation that inclusion brings by drawing on perspectives of a wide variety of people and backgrounds. The Supplier Diversity program will be an important component of our enterprise business strategy, and we will focus on increasing our purchasing and business relationships with TUU suppliers.

Aetna holds corporate memberships and sponsorships that share its commitment to supplier diversity. Examples include the following:

- National Minority Supplier Development Council
- Greater New England Minority Supplier Development Council
- Women's Business Enterprise National Council
- Women Presidents' Educational Organization, Washington DC and New York chapters
- National Gay and Lesbian Chamber of Commerce

6.1.6 Provider Relations and communications

Attachment 5 – Section 6.1.6, Question 1 [SOW 6.1.6]

Describe your provider relations and communications strategy.

PROVIDER SERVICES AND COMMUNICATIONS STRATEGY

Informed and trained providers, who understand the program and what this program means to them and their patients, are critical to success. We will build upon Aetna Medicaid's provider communication methods and strategies to create clear and accurate information for providers. We will use several methods to communicate with providers including regional seminars, individual provider onsite meetings, web portal updates, Provider Manual updates, provider newsletters, webinars, and posting training materials online. These forums will help us communicate access standards, requirements under our Contract with the Agency, and changes to policies, procedures, tools, provider incentives, and member incentives.

Listen, Respect, and Act with Insight, Understanding, Compassion

We are committed to meeting the needs of our providers. To accomplish this, we will assign each participating provider to a Provider Services Representative. By doing so, we will build solid working relationships between representatives and individual practices, allowing us to get more done with each interaction. Our Provider Services Representatives will be just a telephone call away. When Provider Services Representatives or other staff receives a provider inquiry, complaint, or request for information by telephone, they use our call-tracking system to document relevant details, including information regarding the source of the call, the nature of the inquiry, and its resolution. Aetna Better Health will require our Provider Services Representatives to have the education, experience, and training to perform their respective duties before any contact with providers.

Other staff may also handle a provider complaint, depending on its nature. These staff could include the Provider Services Manager, Quality Management Manager, Medical Management Manager or whoever is the most appropriate person based on complaint type. Our Grievances and Appeals System Coordinator handles provider complaints and appeals.

We will also establish a Practice Manager's Advisory Committee that will meet regularly to verify that we are communicating with participating providers on a consistent basis. The meetings will allow for feedback on the provider's perceptions of Aetna Better Health's policies and procedures and provider materials. The group will exchanges ideas, interpretations, and information on current issues and topics and includes various provider types, including primary care, specialists, hospitals, and ancillary providers. Each committee term will be one year; interested providers will need to contact their Provider Services Representative to request nomination to this committee.

When we identify needed updates or produce new materials, it will be the responsibility of the owners of each functional department to communicate changes and provide new material to the corporate communications staff, who will then revise or replace outdated material. We will collaborate with multiple teams to gain insight or approval for all member and provider materials. These teams will review content for compliance to federal and State guidelines. Working with our Legal, Compliance, Member Services, Provider Services, and Aetna Medicaid's Marketing Department, the Communications Department will oversee the development of provider materials for compliance with federal and State guidelines.

Attachment 5 – Section 6.1.6, Question 2 [SOW 6.1.6.1, 6.1.6.1.1, 6.1.6.1.2, 6.1.6.1.3, 6.1.6.1.4, 6.1.6.1.5, 6.1.6.1.6, 6.1.6.1.7, 6.1.6.1.8, 6.1.6.1.9, 6.1.6.1.10, 6.1.6.1.11, 6.1.6.5]

Describe your policies and procedures to maintain communication with and provide information to providers.

POLICIES AND PROCEDURES TO GUIDE PROVIDER COMMUNICATIONS

Proactive and strategic provider communication will begin with Aetna Better Health's first contact with providers and will continue throughout contracting, credentialing, and ongoing operations. We bring a collaborative and conversational approach with providers to make transformative changes.

Physicians are often challenged because they are asked to deliver consistently high-quality care efficiently, implement new information technology, and improve care coordination and patient communication all while empowering patients to take more responsibility for their health. We are here to help.

Provider education and training will play a vital role in supporting the unique needs our members while encouraging efficient billing and other provider interactions. Our Provider Services staff will maintain working relationships with our existing provider network to include communication and providing information to providers. They will assist providers with policy and procedure interpretation, maintaining accurate and current databases relating to provider and facilities, and provider recruitment.

PROVIDER DIRECTORY

Our Chief Operations Officer (COO) is accountable for the integrity of the Provider Directory. When provider information is accurate, members can make appointments easily, claims are processed more efficiently, payments to providers are made more quickly, and communications flow seamlessly between our health plan, our providers, and our members. We estimate that close to 25% of provider contact information changes each year and even the slightest change, a post office box on a billing address or a fax number that is wrong, can create a chain reaction of inconvenience for all parties involved.

The Provider Manual instructs providers to contact Provider Services when they move, add a new location, or make any other change that will affect the accuracy and completeness of the Provider Directory. Once we receive the request, our Provider Services Representative will verify the information, secure the appropriate documentation, and prepare a Provider Change Request for delivery via e-mail to the Provider Data Services team for processing. Our internal audit department randomly audits provider data entries to verify accuracy and integrity of the provider records.

Our online version of the provider directory will be **updated every night**. This version will be available for members and the public. In addition to our web-based directory and our electronic file, we will maintain a hard-copy directory and update it regularly.

Anyone who wants to will be able to print a provider search results from the Aetna Better Health website. If a member calls Member Services and asks for a provider search, we can print it and send it as we would any other piece of member material or correspondence.

PROVIDER MANUAL

Aetna Better Health will develop, maintain, and distribute a Provider Manual to all network providers. It will act as the cornerstone of our provider training and communication, will be easily accessible to anyone via our public website, and offers an in-depth, systematic overview of topics, as required by RFP Attachment 1, Question 6.1.6.1. We will notify newly contracted providers about the Provider Manual and how to access it within five business days from inclusion of the provider into the network.

The Provider Manual will be the providers' principal source of information about Aetna Better Health and we will regularly update the manual to reflect the most recent policy and procedure changes. Our Health Plan Administrator and Medical Director will review the Provider Manual regularly.

Upon request a hard copy of our Provider Manual will be available for all providers, and an electronic copy of the manual will be made available to providers on our provider portal. The Provider Manual will include:

- Program benefits and limitations
- Claims filing instructions
- Criteria and process to use when requesting prior authorizations
- Cost sharing requirements
- Definition and requirements pertaining to urgent and emergent care
- Participants' rights
- Providers' rights for advising or advocating on behalf of his or her patient
- Provider non-discrimination information
- Policies and procedures for grievances and appeals in accordance with 42 CFR 438.414
- Contractor and Agency contact information such as addresses and phone numbers
- Policies and procedures for third party liability and other collections

We will submit all provider communication and education materials to the Agency for approval prior to distribution.

Attachment 5 – Section 6.1.6, Question 3 [SOW 6.1.6.2]

Describe your plan to develop a provider website and describe the kinds of information you will make available to providers in this format.

PROVIDER PORTAL

We will provide a secure, HIPAA-compliant, free online provider portal to allow providers to access critical information such as the Provider Manual, notifications such as authorization notices and remittance advice, and network bulletins. Providers will be required to sign in to access information specific to their panel. The website will be accessible and functional via cell phone.

Information on the provider portal will include:

- The Provider Manual, including the information required by Section 6.1.6.1.
- Provider training information as described in Section 6.1.6.4.
- News and updates from Aetna Better Health, as well as the latest breaking stories from the health care industry as a whole.
- Prior authorization submission and verification – Providers will use WebConnect to file patient claims for payment. We will meet with providers individually to help them become proficient in using these tools and optimizing their functionality.
- Contact information for Provider Services, web portal issues, electronic claims transactions, and claims issues.

We will also publish a Provider Navigation Web Guide as a training aid for using the following tools on our secure provider portal:

- **Member eligibility search** – Verify current eligibility on one or more members.
- **Panel roster** – View members currently assigned to the provider as the PCP.
- **Provider list** – Search for a specific health plan provider by name, specialty, or location.
- **Claim status search** – Search claims by various criteria. Only claims associated with the user's account provider ID are displayed.
- **Remittance advice search** – Search for claim payment information by various criteria. Displays only remits associated with the user's provider ID.
- **Authorization list** – Search authorizations by various criteria. Displays only authorizations associated with the user's provider ID.
- **Submit authorizations** – Use WebConnect to file patient claims for payment. Our policies and procedures help verify the website posts regular updates and contains accurate information.

Our Communications, Information Systems, and Marketing staff will be responsible for publishing new and updated content and materials using our Content Management System. Together, these teams will review the portal quarterly and annually. When we identify needed updates or produce new materials, the owners of each functional department will communicate changes and provide new material to the Communications staff, who will then revise or replace outdated material.

AETNA BETTER HEALTH OF IOWA WEBSITE

Our Aetna Better Health of Iowa website will also available to providers. Through this, we will give our providers unlimited, immediate, convenient, and no-cost access to information specific to their respective programs. It will adhere to HIPAA privacy and security requirements and Section 508 of the Americans with Disabilities Act (ADA) and meet all ADA standards for people with visual impairments and disabilities. Our website applications will include many interactive functions, optimizing a user's ability to communicate and share information with members, providers, and Aetna Better Health staff. We will also include links to other websites with useful information and resources for our providers, including The Agency's Mental Health First Aid page (http://dhs.iowa.gov/mhds-providers/tools-trainings-and-resources/mental-health-first-aid).

Attachment 5 – Section 6.1.6, Question 4 [SOW 6.1.6.3]

Describe your plans for the provider services helpline, including the process you will utilize to answer, route, track and report calls and inquiries.

PROVIDER SERVICES HELPLINE

Our Iowa toll-free provider hotline will be staffed with live-voice coverage 7:30 a.m. through 6:00 p.m.. Central, Monday through Friday, excluding the following holidays:

- New Year's Day
- Birthday of Martin Luther King, Jr.
- Memorial Day
- Independence Day
- Labor Day
- Veterans Day
- Thanksgiving and the day after Thanksgiving
- Christmas Day

Providers calling outside normal hours of operation will hear an automated greeting providing regular hours of operation, inviting them to leave a voice mail, and advising them that they will receive a response to their inquiry by the end of the next business day.

Our policies and procedures will mandate that Provider Services Representatives, under the Provider Services Manager's supervision, retrieve messages from the department's voice mailbox every business morning and respond no later than the end of the day. While there is no requirement that providers seek enrollment verification prior to providing emergency services, providers can check eligibility 24/7 through the Aetna Better Health website.

STAFFING OUR PROVIDER HOTLINE

We will train our Provider Services Representatives to answer provider calls in a timely, accurate, and complete manner. They will respond to a variety of inquiries about topics including claims status and information, member eligibility, and general program information. Provider Services Representatives will also respond to messages left in the provider hotline voice mailbox after-hours on the previous business day. They will assist other departments with provider-related issues, such as updating demographics, checking network participation status, or fielding questions regarding the system's provider screens. Staff meetings, training, and professional development will be scheduled after-hours or during low call volume periods to provide optimum provider hotline coverage.

Local Community-Based Plan - Iowans serving Iowans

Provider hotline staff will be based in Iowa. Reports from our call management system will allow Supervisors to anticipate call volume, supporting sufficient hotline staff scheduling to address providers' needs and satisfy required performance metrics. We will adjust our staffing model to account for the additional call volume and specialization for the Iowa population. We anticipate provider hotline call volume be high during the 60 to 90 days after implementation. We will provide adequate staff, most of who are already cross-trained, to meet these needs.

The Provider Services Manager will handle the development, implementation, and management of our Provider Services training program, including all provider hotline functions. We have a user-friendly, comprehensive training curriculum to accommodate different learning styles. It will include instructor-led classroom sessions, online courses, and on-the-job training. We will supplement training by conducting online assessments of staff understanding, knowledge, and retention and offering additional training as needed. We will document and maintain training course attendance through our learning management system. Annually, we will review and update our training curriculum, or as changes to our programs, Agency requirements, or State and federal laws and regulations occur.

CALL ROUTING

Our toll-free provider hotline will be supported by our call management system. Callers will be greeted with an automated message offering five menu options:

1. Precertify a member (these calls are handled by our Prior Authorization staff)
2. Speak to a Provider Services Representative
3. Verify eligibility
4. Obtain claims information
5. Obtain claims status

The system will route all incoming provider calls, whether a claims inquiry, issue, or complaint, to the Provider Services Representative with the training, skills, and experience to resolve the issue. However, if the Provider Services Representative requires additional assistance, the telephone system will support seamless transfer of any incoming call within the team or to a different area of Aetna Better Health. Our Provider Services Representatives complete training on how to effectively transfer provider calls to the appropriate resource. Each telephone extension will have a voice mailbox, allowing our staff to retrieve and respond to messages left by providers. Providers who call after-hours will be able to leave a recorded message to which a Provider Services Representative will reply no later than the end of the next business day.

We will provide a call redirect feature that enables rerouting of calls to any Aetna Better Health call center. This will afford providers uninterrupted access to Provider Services Representatives if we have a business interruption due to a disaster. We will mitigate the risk of such interruptions through telework.

Attachment 5 – Section 6.1.6, Question 5 [SOW 6.1.6.4, 6.1.6.4.1, 6.1.6.4.2, 6.1.6.4.3, 6.1.6.4.4, 6.1.6.4.5, 6.1.6.4.6, 6.1.6.4.7, 6.1.6.4.8]

Describe your provider training plans.

CUSTOMIZED ORIENTATION GIVES NETWORK PROVIDERS A SUCCESSFUL START

Listen, Respect, and Act with Insight, Understanding, Compassion

As detailed above, outreach to local providers is underway. These efforts include discussions with providers regarding our training and orientation programs. We will offer our formal provider orientation session to newly contracted providers 60 days before the Contract starts. Local Provider Services Representatives will host the orientation with assistance from Medical Management and other department leads, such as claims, to help answer provider questions. We will also provide online orientation webinars 60 days before the Contract starts so providers who cannot attend in person can view the training at their convenience. Once the Contract has begun, we will strive to schedule orientation within the first two weeks for new providers who join our network. We will complete the initial training no later than 30 days after signing a contract.

During our new provider orientation, our local team will meet in person, onsite, with providers and their staff to introduce the requirements and processes. Our orientation will cover Iowa High Quality Healthcare Initiative standards and Aetna Better Health requirements. Providers will learn how we will support them in managing member care and achieving optimal health outcomes. We will also emphasize the role of administrative processes and appropriate billing practices as well as demonstrate online tools, such as how to submit, look up, and view the status of an authorization.

Local Based Plan

After our providers complete orientation training, our Provider Services Representatives will conduct follow-up office visits to reinforce training for providers and their staff. **We meet in person with our providers regularly to build relationships and rapport.** At a minimum, Provider Services Representatives will meet with individual providers onsite twice per year. They will cover a variety of topics during these provider office visits and will come prepared with claim history so they can discuss provider-specific billing issues.

Provider Services Representatives will also communicate updates or changes to program standards, laws, regulations, and Aetna Better Health requirements. While Provider Services Representatives will use regularly scheduled visits to provider sites as an opportunity for educational touch points, we will supplement these routine provider office visits with ad hoc provider office visits, emails, webinars, and statewide provider educational forums.

We will send e-mail and provider portal notifications of critical billing and claims concerns, formulary changes, and new Medical Management topics. We will also publish our quarterly provider newsletter, which will be posted to our portal, and provide new information each issue. Providers can access training online at their convenience. Provider Services will track and monitor providers who complete online training.

COMPREHENSIVE PROVIDER TRAINING PLAN

Our Provider Services Department will develop, conduct, and maintain all provider training and attendance documentation. Aetna Better Health Provider Services staff will have a physical address in each Service Area to facilitate in-person meetings with providers. Our training program includes:

- Education on covered services, such as behavioral health and pharmacy
- Claims and billing processes, including dispute resolution processes
- Member eligibility and rights and responsibilities
- Contract requirements and provider responsibilities
- Prior authorization/utilization review, policies and procedures
- Cultural competency
- Reimbursement for assessing children's behavioral health needs in their offices
- Non-traditional therapies available to providers
- Medicaid policies including updates and changes
- The 24/7 Behavioral Health Crisis Line, Mobile Response Crisis teams
- 24/7 Nurse Call Line
- The role of the Case Manager
- Additional training related to Assessment and treatment planning, psychiatric services, substance use disorders services, medication management, inpatient services, outpatient therapy, intensive outpatient services and case management services.
- Early intervention and health screening for identification of behavior health problems and patient education (for behavioral health providers)
- Use of behavioral health screening tools (for behavioral health providers)
- Critical incident training (as described in Attachment 1, Section 10.4.3. of the RFP)
- Abuse and neglect training including procedures and requirements for preventing, identifying, reporting, investigating, and remediating suspected abuse, neglect, and exploitation of members

Our training programs will follow the Agency's Contract requirements and applicable state and federal laws. All new providers will receive this initial training within 30 days. We will re-educate providers' staff as needed. We will provide additional trainings as we implement new benefits and make changes.

Training will cover topics applicable to all network providers plus additional topics that are specific to specialty providers or PCPs. Topics will include policies and procedures about providers' respective programs, operations, and specialized services.

SMOOTHING THE TRANSITION TO MANAGED SERVICES FOR LTSS PROVIDERS

Pioneer in Fully Integrated Care We recognize that many LTSS providers do not have experience contracting with or billing managed care organizations. As such, we will supplement our training with additional education specifically targeted to their needs and assist these providers in rendering services under the Iowa program through assistance with features such as information technology, billing, and systems operations. This includes:

- **Providing web portal access and training to LTSS providers** – The portal will include all training and technical assistance material developed for Iowa LTSS providers, including recorded webinars, reports, documents, and requirements for participation in an MCO network. This one-stop resource will allow LTSS providers to learn our Contract requirements and to connect with our provider network.
- **Offering statewide technical assistance to LTSS providers** – Through technical assistance, we will demonstrate our accountability requirements for delivering LTSS supports and what we will require from LTSS providers. For smaller providers that may have limited information technology capability, we will develop workarounds that allow the provider to participate in the network.
- **Facilitating access to practice sessions for key accountability requirements** – Many operational issues are addressed in practice sessions or recorded webinars that can be accessed remotely. We will offer and facilitate access to these practice sessions to reduce friction of denied payment or missed reporting.
- **Improving efficiency through web-based payment remittance and fulfillment** – We will offer our LTSS providers the ability to submit claims electronically through our subcontractor Emdeon. Through the use of Emdeon's solution, which is designed to easily integrate with existing technology infrastructures, LTSS providers will be able to improve efficiency, reduce costs, increase cash flow and more efficiently manage the claims submission process.

6.1.8 Notification of provider disenrollment

Attachment 5 – Section 6.1.8, Question 1 [SOW 6.1.8]

Describe procedures for ensuring continuity of care and communication with members when a provider disenrolls.

ENSURING CONTINUITY OF CARE FOR MEMBERS

Committed to Health Care Transformation The Provider Manual and the provider's contract outline the provider's rights and instructions for terminating their contract with Aetna Better Health. These instructions require the provider to notify the Provider Services Department in writing in advance of the termination.

The Provider Services Department will pull a report of recently terminated providers for members who are assigned to a PCP or have seen a specialist within the last 12 months. The Provider Services

Department will mail letters to affected members indicating that the provider will no longer be in our network as of a specific date.

In our letters regarding a terminating PCP, we will inform the member of their options, including auto-assignment to a new participating PCP within the same provider group or within their area, or working with Member Services to select a new PCP. A Member Services Representative will facilitate the transition process so that care for members is not disrupted.

If a member is in active treatment, we will send a letter with a transition of care plan to the member. As necessitated by the circumstances, our Medical Management staff will also contact each member in active treatment to help meet ongoing clinical needs and maintain a Care Plan throughout the transition. Members in active care can remain with their current providers (PCP or specialist) regardless of whether the treating provider still belongs to our network.

We prioritize ensuring members maintain:

- Existing provider relationships that they wish to continue
- Continuity of care with specialty providers

To that end, should a provider disenroll, we will provide out-of-network authorizations for members as needed. A fundamental tenet of our transition plan for all members is a thorough vetting of the ongoing clinical needs of members in active treatment. For members in active treatment or with special health care needs, we will take on the administrative burdens typically associated with transitioning care.

Our Member Services Representatives will be specifically trained to assist members who need:

- Continuation of specialty care
- Pharmaceutical management
- Anticipated hospitalizations or surgeries
- Active case management

Please also refer to our response to RFP Attachment 5, Section 9 for details regarding the procedures we will implement to provide continuity of care for members.

NOTIFYING STAKEHOLDERS OF PROVIDER CHANGES AND UPDATES

Our online version of the provider directory will be **updated nightly**. This version will be available for members and the public. The Member Handbook, welcome packet, member website, and the welcome letter inform members of the availability of our Provider Directory, along with instructions for calling Member Services to obtain the most up-to-date Provider Directory information. Member Services Representatives will be available to assist members in accessing the Provider Directory.

We also make an electronic and hard copy Provider Directory available to the Enrollment Broker. After initial enrollment and at least annually thereafter, we will notify members that they may elect to receive an updated Member Handbook and Provider Directory.

6.1.9 Medical records

Attachment 5 – Section 6.1.9, Question 1 [SOW 6.1.9, 6.1.9.1, 6.1.9.2, 6.1.9.4]

Describe your process for transmitting and storing medical data, including the use of technology and controls to ensure confidentiality of, and access to, medical records.

We are committed to providing access to best-practice health care for the Iowa program and population while protecting the privacy of our members. As detailed in our response to RFP Attachment 5, Section 13.1, Question 6, central to our process for transmitting and storing medical data, will be compliance with both HIPAA and the Health Information Technology for Economic and Clinical Health (HITECH) act.

Per the HIPAA mandate, we will require providers to submit claims and other HIPAA transactions using the National Provider Identifier (NPI). We will monitor claims and other inbound transactions though compliance-checking software used internally and by our designated clearinghouses. Security standards will be adopted so that the integrity and confidentiality of electronic records and transmissions are protected.

We will prioritize each member's right to privacy and treat Protected Health Information (PHI) with the strictest confidence. We will only share PHI with others when it is appropriate for delivery of health care services, administration of health care benefits, rendering of health care payments, or as otherwise required by law. We will implement a risk management process along with a secure messaging system to encrypt e-mail traffic for PHI or other confidential information across the Internet.

We will provide ongoing privacy regulations training to staff, including twice-monthly e-mails and annual mandatory educational in-service training sessions. All new hires will receive mandatory HIPAA and HITECH privacy and security training as part of orientation and then quarterly thereafter.

HIPAA BEST PRACTICES: TRANSMITTING AND STORING PHI

Aetna Medicaid's Privacy Office will have overall responsibility for developing policies and procedures to safeguard PHI against uses and disclosures that are inconsistent with applicable law.

Our Iowa-based Compliance Officer, supported by our Privacy Office, will implement a Privacy Compliance program that will include an educational component and ongoing policy and procedure review for maintaining our members' privacy and confidentiality. The Compliance Officer will also make certain that our staff is thoroughly trained on privacy policies and procedures, and for overseeing the implementation and enforcement of these policies and procedures.

We are developing and will maintain policies and procedures that address the proper handling, use, and disclosure of members' PHI while administering their health care benefits and providing an appropriate level of customer service. We will update policies and procedures annually and as needed to stay up to date with changes in legislation and to verify they are current and complete.

To further safeguard PHI, we will send periodic reminders to all staff, focusing on specific aspects of the proper handling and storage of PHI. All staff must complete compliance and ethics privacy training upon hire and quarterly thereafter.

ADMINISTRATIVE, PHYSICAL, AND TECHNICAL SAFEGUARDS

We will have administrative, physical, and technical safeguards in place, including:

- Workforce security
- Workforce clearance and termination procedures
- Information access management
- Encrypting all e-mails that contain member-specific health and financial information

Through an annual HIPAA risk assessment, we will evaluate the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic PHI, with our business unit privacy and security leaders working closely on all assessments and audits.

We will maintain contingency operations and a facility security plan, requiring access control and validation for all staff and upholding strong workstation use policies and security procedures. We will adhere to the HIPAA technical safeguard requirements, employing unique identification procedures and setting all computer terminals to automatically log off when unattended. We will guard against unauthorized access of electronic PHI with a stringent transmission security policy to protect against data being transmitted over an electronic communications network.

BUSINESS ASSOCIATE SAFEGUARDS

As specified by the HIPAA organizational requirements, we will have a business associate agreement with all third parties who receive our members' PHI. This agreement will require business associates to adhere to the security and confidentiality standards defined by both HIPAA and HITECH. The policies and procedures we are developing will be up-to-date with the changes in both HITECH and the HIPAA Omnibus Rule effective March 26, 2013. Our breach notification process will mandate a privacy or security breach notification to members.

POLICIES AND PROCEDURES TO VERIFY PROVIDER COMPLIANCE WITH MEDICAL RECORDS REQUIREMENTS

Our Provider Manual, supported by the provider contract, will inform providers that they must comply with Iowa law (Admin. Code 441 Chapter 79.3), which states that each provider must document all medical services that the member receives and maintain members' medical records in a detailed and comprehensive manner that:

- Conforms to good professional medical practice
- Permits effective professional medical review and medical audit process

Table 6-4 outlines our strategy for monitoring, evaluating, and implementing improvements for Records Management.

Table 6-4: Records management strategy

Focus	Improvement strategies
Monitoring	• Completing medical record reviews during the HEDIS hybrid review process • Completing utilization management record review • Performing quality of care investigations • Completing routine medical record reviews • Completing reviews during the grievances and appeals process
Evaluating	Confirming that all records received by the health plan are managed under HIPAA requirements through: • Onsite audits • Credentialing • NCQA audit
Implementing	• Using confidential storage • Requesting the minimum necessary information • Following all other HIPAA requirements regarding personal health information

REQUIREMENTS OF PROVIDERS

We will require that providers maintain an adequate and complete medical record for each member. Providers may maintain electronic records if the record-keeping format is capable of being printed for review. Our providers will be held contractually responsible for maintaining medical record systems to protect the confidentiality of PHI.

We will require our providers to:

- Keep current, detailed, organized, and comprehensive records to promote effective member care and quality review and to document patient health information to meet the needs of continued patient care, legal requirements, research, education, and other legitimate uses
- Maintain the records in a way that protects member integrity and ensures their confidentiality, proper use, accessibility, and availability to each member as required by law
- Store medical records in an area that does not allow for unauthorized retrieval

A MEMBER'S RIGHT TO MEDICAL RECORDS

Both our Member Handbook and member website will prominently display our members' right to obtain a copy of their medical record at no charge. We will train our Member Services Representatives to explain the rights of all members to:

- Receive a copy of their medical records
- Obtain the copy at no charge
- Request amendments or corrections
- Ask providers to transfer the member's medical record to another provider

If a member is having difficulty with a provider facilitating the transfer of medical records, our Member Services Representatives will assist with the process.

TRANSFERING MEDICAL RECORDS BETWEEN PROVIDERS

We have developed a policy that will provide for the transfer of relevant information, including medical records and other pertinent materials, between providers to verify a smooth transition.

If a member changes their PCP, the previous PCP will forward, at no cost to the plan or the member, the member's medical records to the member's new PCP within 10 days of the request or before the next scheduled appointment with the new PCP, whichever is earlier. Further, when a PCP refers a member to a specialist, the specialist must forward, at no cost to the plan or the member, appropriate notes, x-rays, reports, or other medical records to the specialist before the member's scheduled appointment. Specialists must communicate in writing with the PCP to maintain the continuity of health services for ongoing treatment. All summaries, evaluations, or recommendations should be mailed or faxed within two weeks from the date of service.

We will also work with providers who are not in our network to confirm there is a smooth transfer of care to appropriate network providers. This happens when a newly enrolled member has an existing relationship with a medical health, behavioral health, or substance use disorders provider outside of our network. We also facilitate and secure the member's records from the out-of-network providers as needed.

6.1.10 Availability of services

Attachment 5 – Section 6.1.10, Question 1 [SOW 6.1.10]

Describe your plans to ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable Medicaid members.

ENSURING AVAILABILITY OF SERVICES AND ACCESS TO CARE

We will build, manage, monitor, and maintain a fully compliant provider network that will improve overall access to care and reduce cost. We will contractually require our network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable Medicaid members. We will then monitor our network to make certain that **every member has access to services and supports they need *when they need them***.

Our approach for providing timely access will include the following components:

- Maintaining a strong provider network by monitoring network adequacy and targeting provider recruitment activities
- Use of PCMHs which encourages after-hours participation
- Documenting hours of operation in the provider application process
- Including appointment wait time standards, and call-coverage requirements, in the Provider Manual, provider orientation materials, and provider contracts
- Hosting provider training sessions and posting information to our provider portal
- Conducting ad hoc and in-service provider office visits to address access concerns one-on-one
- Conducting ongoing monitoring and studies of appointment and after-hours availability
- Following up with providers who do not follow appointment wait time and after-hour standards per our provider agreement
- Collaborating through health plan committees
- Engaging Care Managers when appropriate
- Using a Provider Value-Based Care program to incentivize providers for meeting required standards
- Working with providers one-on-one to improve access

All provider contracts will include a Non-Discrimination and Equitable Treatment of Members clause that requires the provider to treat each member equitably and serve each member with the same degree of care and skill as customarily provided to commercial members or comparable Medicaid members. Providers are mandated not to discriminate against members on the basis of race, ethnicity, gender, creed, ancestry, lawful occupation, age, religion, marital status, sexual orientation, mental or physical disability, medical history, color, national origin, place of residence, health status, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment for services, cost or extent of Physician Services required, or any other grounds prohibited by law.

We also share best practices with providers to improve appointment and after-hours availability. For example, one of our health plans worked with a family practice whose members had a pattern of high Emergency Department (ED) utilization. The plan determined that this was partially attributed to lack of appointment availability at the practice. The plan recommended the implementation of an open-access appointment system. As a result, the provider realized a 10% reduction in ED visits among their patient panel and an improved no-show rate from more than 30% to 15%.

PROVIDING AFTER-HOURS COVERAGE TO OUR MEMBERS

Appointment accessibility requirements will be met through ongoing monitoring of primary care availability and capacity. We monitor compliance on a recurring basis using:

1. A cross-functional team that meets weekly to evaluate member complaints, including those regarding after-hours access
2. Monthly site visits to PCP offices where Provider Services Representatives emphasize after-hours access standards
3. Evaluation of ED data to determine whether a PCP is noncompliant with after-hours access requirements
4. Availability surveys sent to members that include questions regarding after-hours access
5. Annual provider surveys, where we assess ability to accommodate after-hours access according to standards.
6. Provider secret shopper surveys by telephone regarding appointment and after-hours access for primary, maternity, and high-volume specialty care

Through these sources, we will be able to individually identify providers who do not meet standards and conduct follow-up for education and improvement purposes.

PROVIDER EDUCATION AND REMEDIATION FOR AFTER-HOURS ACCESS

We are committed to providing our members access to the care they need, when they need it. This means that our members will be able to receive the same level of assistance from us at 1:00 a.m. as they would expect to receive at 1:00 p.m. To do this, we need to provide abundant and appropriate access to care to our members in a manner that meets their needs and their schedules.

Aetna Better Health will contractually require all PCPs to be available and accessible 24/7. We will also implement a PCP after-hours program to incentivize providers. Participating PCPs who see a member after regular office hours will receive additional reimbursement for after-hours care. This will provide members have an opportunity to see a PCP in lieu of an ED visit. Through this program, the PCP does not have to be the member's PCP of record.

Our toll-free Member Services line will capture information regarding the dates and times a member tried to contact a PCP, which will interface with Aetna Better Health's call-tracking system. This system will send an automated notification to the Provider Services Department, which will contact the provider and follow up as necessary. Member Services Supervisors will routinely review call documentation to determine whether a complaint should be filed. If a member elects to submit a complaint, the Member Advocate will initiate the formal complaint process within our Complaint and Appeal Database.

Every month, our Member Advocates will forward complaint information related to access to care and appointment availability to our Quality Management (QM) Department. QM staff will track and trend complaints received concerning provider access issues and consults with the appropriate network Manager and Provider Services team. If we identify a provider who fails to meet the Agency's appointment availability or after-hours coverage requirements, these departments will work collaboratively to determine the best course of action based on the number of complaints, current negotiations, or level of severity of the complaints. Follow-up actions may include an onsite office visit by a Provider Services Representative for re-education. If the provider's behavior continues, Provider Services will execute a Corrective Action Plan (CAP). If a resolution is still not achieved, we will terminate the provider's contract. Once the issue is settled, we will notify the member of the resolution.

6.1.11 Provider compliance

Attachment 5 – Section 6.1.11, Question 1 [SOW 6.1.11]

Describe procedures for ensuring network providers comply with all access requirements and for monitoring providers for compliance.

MONITORING PROVIDERS FOR COMPLIANCE WITH ACCESS REQUIREMENTS

Nobody likes to be kept waiting, including our members. Long delays in getting an appointment or waiting to see the provider once a member is in the office is frustrating, time wasting, and can lead to members switching providers or plans. Another consideration is the potential for a member receiving rushed or sub-optimal care if a provider is running behind.

Therefore, as our members' primary advocate in promoting optimal health care outcomes and access to care, Aetna Better Health will use a coordinated and proactive approach to verify and monitor our network availability of appointments and office wait times meets or exceeds the Agency's requirements. We will use a variety of inputs and data to do this including listening to members and providers, reviewing feedback from our transportation contractor, and analyzing data and reports from internal departments such Member Services, Network Development, Grievances and Appeals, Medical Management, and Quality Management.

COLLABORATING WITH PROVIDERS TO IMPROVE WAIT TIME

Timely appointments help members get care when they need it. We will work with our providers to facilitate member access to the right services, at the right time, and at the right level of care. This collaboration will include continuing education, training incentives, and recurring visits by our Provider Representatives. We will also assist members and providers, though our transportation contractor, to help members get to their appointments when they face transportation challenges.

Provider Services will use several monitoring tools to assess access standards, appointment and after-hours availability, and wait-time compliance. We will use this data to improve access to care at both the individual provider and overall network levels.

Our strategy for monitoring compliance with appointment wait time and after-hour standards includes:

- Monitoring overall network adequacy using GeoAccess and other reporting
- Monitoring member complaints, grievances, appeals, and satisfaction data related to appointment wait times
- Reviewing the annual appointment availability survey and report
- Reviewing the annual after-hours study and report

If we determine that, based on this data, that the provider performance is unacceptable or does not meet requirements, we will take corrective action to remedy any issues both internally and with providers. If the CAP includes making improvements at the provider's level, we will follow up with the practice to verify that these improvements have been completed.

PROVIDER EDUCATION HELPS MINIMIZE APPOINTMENT WAIT TIMES

We will follow a focused approach to helping our providers succeed in rendering excellent customer service and quality care to our members via education and training. Likewise, we want our members to know their rights to timely care. At Aetna Better Health, the first step will be training our internal staff by creating and disseminating written policies and procedures about educating our providers and

members regarding access requirements. This training will be part of staff orientation and will be accessible anytime to staff online via our staff portal.

Having educational information easily accessible for providers is the second step and, so we will publish appointments and access standards in the Provider Manual, which will be available online 24/7. We will also cover appointment standard, office wait time, and after-hours requirements during provider orientation. The third step is educating our members about access and appointment standards so they can be their own advocates and hold both providers and us accountable.

This process includes educating:

- Our staff on how they can ease administrative burdens for both providers and members and assist a member in being seen within established timeframes
- Providers about how we can help them achieve wait time goals and help them understand the policy for after-hours service
- Members about their rights so they can be their own advocate if a provider is not meeting standards and how they can initiate a grievance or appeal

We will coordinate with providers in our network to achieve compliance with appointments and wait time standards, including the time it takes to get an appointment, acceptable wait time in the waiting room and exam room during a scheduled appointment, and provider availability for telephone consultation after regular business hours. Our internal and external written policies and procedures will describe our monitoring process and actions we will take with providers who do not meet standards. Our policies and procedures will include provisions for educating providers and working with them to develop and implement corrective actions in the event the provider does not adhere to the requirements.

HAVING ACCURATE, TIMELY DATA IS CRITICAL TO ONGOING MONITORING AND VALIDATING PROVIDER COMPLIANCE

We will monitor and validate provider compliance with access standards using a team approach that includes Provider Services, Quality Management, Network, Grievances and Appeals, and other departments as appropriate. We will use access-related data from each department to assess whether standards for appointment availability, wait times, and provision of appropriate after-hours coverage.

We will create and submit quarterly GeoAccess reports documenting the geographic availability of network providers, including PCPs, hospitals, pharmacies, and all specialties and data as required by and documented in the Systems Companion Guide. Our GeoAccess reports also will include an analysis of provider to member ratios in each required geographical area.

TAKING ACTIONS TO REMEDY PROVIDER NONCOMPLIANCE

When we identify a provider who fails to meet appointment availability or after-hours coverage requirements, our Quality Management and Provider Services Departments will determine the appropriate actions, which may include:

1. **For providers with no previous deficiencies** – We will first mail a re-education letter to remind the provider about our contractual requirements for appointment availability and what constitutes inappropriate wait times for members.
2. **For providers with prior complaints or deficiencies** – Provider Services conducts in-person re-education that is tailored to meet the needs of that particular provider.

3. **For providers who fail to comply or refuse to discuss the deficiency** – The provider may be required to submit, within 30 days, a CAP that identifies detailed improvement milestones to return to compliance within an appropriate timeframe. We will contact the provider to follow up on progress related to the CAP and report status to the appropriate Clinical and Administrative Advisory Committee. Once the provider successfully completes the CAP, a Provider Services Representative will conduct a follow-up audit to verify continued compliance with standards. A summary of actions will be presented to the QMOC.
4. **If non-compliance continues** – The Clinical and Administrative Advisory Committee may restrict new members assigned to the provider's panel or terminate the provider contract.

Attachment 5 – Section 6.1.11, Question 2 [SOW 6.1.11]

Describe emergency/contingency plans in the event a large provider is unable to provide needed services.

Stability, Competency, and Trust in the Face of Challenge

Our assigned staff will routinely monitor the network for viability and continuity, focusing on providers with known or suspected viability problems or known to be at-risk for closure. This monitoring will serve as an early warning system and allow network staff and management to identify possible loss, prevent abrupt closure, prevent member disruption, and provide for seamless delivery of services to members.

Network staff will use the following key indicators in our monitoring process:

- State licensure issues
- Medicare and Medicaid sanction reports
- Credentialing or re-credentialing concerns
- Failure to secure or renew required insurance
- Multiple facility requests within short timelines for advance payments to cover expenses
- Concerns raised by Care Managers, Quality Management, and Provider Services that suggest potential facility closure
- Member or provider complaints about the availability of care or services

We also will perform this monitoring through formal notices from the Agency, State, and other authorities; notification from our commercial counterparts of potential issues; local news reports; and ongoing relationship management with our providers through our local Network and Provider Services teams.

However, we recognize that there may be a rare instance where our monitoring efforts are unable to predict an emergency. In these cases, we will maintain documented protocol for modifying our operations in the event of an emergency. Please refer to our response to Attachment 5, Section 13.2 for our disaster recovery and continuity plan which includes the strategy for recovery after an expected loss of network providers or large service sites that creates an emergent need for coordinating transfers of large groups of members or members with special health care needs.

Three Decades of Caring for Those Most Vulnerable

We will also draw from the 30-year experience and nation-wide knowledge base of Aetna Medicaid, including our Delaware plan. When the State of Delaware asked for the plan's assistance to transition members from another MCO due to contracting issues, they readily agreed. Their first priority was to assist the sick children in Delaware that would be immediately displaced from the only children's hospital in the state, while simultaneously losing access to the majority of all pediatric specialists.

In order to take on 12,000 members in a few weeks, the health plan worked diligently with the state and the other MCO to intake member profiles and current utilization plans. They accepted the current treatment plans for this membership and placed appropriate authorizations in place. Case managers reached out to these families to make certain their immediate and long term needs were met. This Aetna Medicaid plan was able to scale its member services, appeals, and claims staff in order to accommodate the increased transactional work. Member calls were answered promptly and provider claims were paid without interruption to their service delivery.

6.2 Network development and adequacy

Attachment 5 – Section 6.2, Question 1 [SOW 6.2.1, 6.2.2, 6.2.2.1, 6.2.2.2, 6.2.2.3, 6.2.2.4, 6.2.2.5, 6.2.2.6, 6.2.2.7, 6.2.3]

Describe in detail your plans to develop and maintain a comprehensive provider network, including goals and tasks and the qualifications and experience of the staff members who will be responsible for meeting network development goals.

Local Community-Based Plan - Iowans serving Iowans

As detailed, above, in our responses to the questions in Section 6.1, our network will include PCPs, specialist physicians, mental health providers, substance use disorders providers, hospitals, pharmacies, FQHCs, Urgent Care Clinics, HIV/AIDS Services Organizations, Indian Health Service Providers, and other ancillary service providers. We use the GeoAccess program to review the medical provider network against our membership to monitor network disruption. This response details our plans to recruit and maintain an effective provider network; please refer to our responses to questions in Section 6.1 for additional details regarding the goals and tasks that we will address to create a comprehensive provider network.

Members will have the right to choose to receive care from any of our contracted in-network providers regardless of the reimbursement rate negotiated with the provider. When establishing and maintaining our network, we will adhere to the guidelines set forth in Attachment 1 to the RFP, Section 6.2.2.

How to recruit and support an effective provider network: Simplifying it for providers

Over time, Aetna Medicaid has learned what is important to providers during the recruitment process—chiefly, making things simple for providers. Table 6-5 highlights some of the ways Aetna Medicaid has simplified the provider recruitment experience:

Table 6-5: Provider-centric recruitment

Provider portals	Contract information, FAQs, Clinical Guidelines—all available online. Filing claims, requesting authorizations, checking eligibility and more—all available 24/7/365. No time wasted on the telephone.
Provider Services staff	Recruited from Iowa, knowledgeable, helpful, and highly mobile. Providers can call or text them directly—no need to go through an endless 1-800 call tree. They can be there in person when needed.
Provider training	Gets providers and their office staff up and running. Training is available in the office, in community-based meetings, and through online resources.
Provider credentialing	Streamlined approach gets providers through credentialing quickly.

Experienced, local staff responsible for meeting network goals

Supported by the national resources of Aetna Medicaid, our locally based network resources will execute ongoing network development and monitoring activity. Together we will execute the initial build and collaborate with local plan management throughout the process. During implementation, the Head of Medicaid Network will work closely with the Regional Network Market Head and local Director of Network Management. Iowa's local Director of Network Management will be responsible for developing and executing our Network Development and Management Plan and validating it meets the Agency's requirements listed in Section 6 of the Iowa High Quality Healthcare Initiative RFP. Roles and responsibilities are further defined in Table6-6 below.

Table 6-6 Network Development Roles and Responsibilities

Position	Responsibilities	Qualifications	Number of years' Experience
Director of Network Management	Oversees network development once the plan is operational and, pending hire date, will work with the build team to complete the initial network build. The Director will also be involved with the build prior to go live, depending on the hire date. He or she will work closely with the plan CEO or COO to coordinate communication with the Agency. Typically the CEO or COO will be the first point of contact.	• Bachelor's degree (MBA/Masters degree preferred) • Must possess local knowledge of Iowa providers • Must possess a successful track record negotiating large hospital system contracts. • Comprehensive understanding of hospital and physician Medicaid/Medicare financial issues and how to leverage technology to achieve quality and cost improvements for both payers and providers.	• 4-6 years of Network Management • 4-6 years of Leadership • 4-6 Years of Government Relations
Network Manager	Reports to the Director of Network Management. Works to establish relationships and build existing network needs for enrollment and support ongoing network growth. Coordinates and collaborates with National Network Resources as needed.	• Bachelor's degree (MBA/Masters degree preferred) • Must possess a successful track record negotiating large hospital system contracts. • Comprehensive understanding of provider Medicaid/Medicare financial issues and how to leverage technology to increase quality and cost savings • Must demonstrate proficiencies of Contract Negotiator responsibilities	• Minimum of 3-5 years of negotiating provider agreements; experience with Medicaid contracting is strongly preferred • 4-6 years - Network Management/Network market leadership • 4-6 years - Network Management/Provider relations experience • 4-6 years Network Management/Contract negotiations • 4-6 years Network Management/Provider connectivity
Contract Negotiator	Responsible for negotiating contracts as providers are added after implementation	• Bachelor's degree desired or equivalent work experience • Communication Skills - Strong written and verbal communication skills. Able to identify and capitalize on marketing opportunities to support program delivery • Mastery of provider contracts, contracting options, PADU guidelines as well as provider configurations	• 4-6 years of related experience with contract negotiations, provider relations • 4-6 years of Network Management/Physician recruiting - medical

Position	Responsibilities	Qualifications	Number of years' Experience
Chief Medical Officer (CMO)	Acts as the senior executive responsible for overseeing the performance of provider subcontractors.	• M.D. or D.O., Board Certification in a recognized specialty including post-graduate direct patient care experience • Advanced degree in Business or Public Health desirable • Active and current state medical license without encumbrances • Demonstrated ability to make strategic decisions based on a thorough understanding of industry issues, trends and the regulatory landscape • Demonstrated ability to create business strategy to drive competitive advantage and shift direction as market conditions dictate • Demonstrated ability to interact successfully with external providers • Sound clinical knowledge and recognized as a credible clinical resource • General knowledge of the health benefits business, clinical issues, trends, and medical management. • Interpersonal and listening skills that bring out the best in medical management staff. • Effective and skilled public speaker and exceptional presentation skills. • Ability to build a high performing team by promoting a culture of energy and commitment, mentoring employees and supporting ongoing training and development of staff. • Ability to successfully operate in a highly matrixed and changing environment.	• 3-5+ years of experience in the health care delivery system, e.g., clinical and health care industry required with 3-5 years additional leadership and management experience in the health care industry

Position	Responsibilities	Qualifications	Number of years' Experience
Credentialing Specialist	Ensures that the provider network is credentialed and re-credentialed in a timely manner and in coordination with provider services contracting activities.	• Preference will be given to applicants with at least a Bachelor degree in Business or Health • Prefer experience in provider credentialing and/or provider relations • Incumbent must process effective problem-solving skills and ability to make and implement operations decisions independently.	• Prefer a minimum of two years research and analysis experience, or at least one year of health care related experience, with preference in managed care background and a minimum of two years developing database applications
Manager, Provider Services	Part of ongoing operations. Provides initial and ongoing provider education. Works with and monitors contracted providers to see that they are following policy and procedures, quality of care is being provided, and access standard are met (e.g., timely appointments).	• Bachelor's degree or equivalent work experience (advanced degree preferred) • Major program development experience in support of network management and provider contracting operations • In-depth knowledge of managed care business and health care environment; Medicaid managed care experience preferred	• A minimum of three years of industry experience in a similar role
Provider Phone Rep	Creates and/or manages cooperative working relationships with providers and/or through personal visits, correspondence and telephone contact.	• Thorough knowledge of managed care business and health care environment	• 1-3 years of related experience
Provider Services Liaison	Responsible for developing and maintaining relationships with physician and business leadership of key physician groups, ancillary providers, and delivery systems	• Bachelor's degree desired • Demonstrated knowledge of medical cost drivers and managed care industry • Demonstrated ability to synthesize and translate competitive intelligence into decision-making process	• 2+ years related experience

Maintaining a great provider network by development of quality relationships

Quality and Value through Simple, Relevant Solutions

We apply a collaborative, bi-directional, conversational approach with providers to make transformative changes. We will tailor our contracts specifically to Medicaid with dedicated staff who can talk to the providers about unique program needs. Our team will be based in the communities they serve, fostering a higher level of responsiveness and more personal relationships.

As detailed in our responses to RFP Attachment 5, Section 10.3 and Section 6.1.2, Question 4, we will offer comprehensive Provider Value-Based Solutions (VBP), based on our nationally recognized programs that reward providers for improving member outcomes and transforming their practices. Our VBP will feature value-added incentives to further Iowa's Medicaid program goal of expanding innovative payment models and provider competencies related to integrated population health. We will bring to Iowa our national expertise and experience in creating new and innovative ways to collaborate with providers, creating a new culture and mindset of delivering quality, patient-centered care.

Using our VBP programs, provider quality performance reporting, and advanced technology tools, we will create a sustainable, coordinated system of care that delivers the best care for members, delivering on the triple aim of reduced costs, improved population health outcomes, and an improved patient experience of care.

Managing provider network adequacy

As detailed in our response to Section 6.1, Question 2, we will monitor our network regularly to verify that every member has reasonable access to services and supports they need. We are developing enhanced policies, procedures, and processes to monitor our provider, subcontractor, and affiliate networks to provide adequate network capacity, accessibility for our members, and accuracy in our provider listings. Further, our network activities connect our members with a health care home so that they can obtain services in the most effective and appropriate setting. Our goal will be to meet and exceed State requirements for access.

Committed to Health Care Transformation in Iowa

We will rely on frequent running of GeoAccess reports to measure how our network stands against the State's requirements as our baseline measurement. In addition to using GeoAccess for distance reviews, we will use additional monitoring activities for each network category, including:

- Conducting provider secret shopper surveys by telephone regarding appointment and after-hours access for primary, maternity, and high-volume specialty care
- Reviewing providers' panel status to confirm if new members can be assigned and identify providers that have reached capacity or referral limits
- Reviewing PCP-to-member ratios by provider type and by region to make certain an adequate number of PCPs are available
- Following up and resolving member concerns related to access or appointment availability
- Reviewing quarterly analysis and trending of member grievances to identify any potential availability or accessibility issues; perform root cause analysis; and develop corrective action plans if necessary
- Identifying potential members for care coordination who are using the ED for non-emergent conditions
- Making daily updates to online Provider Directories to reflect changes in open/closed panels

- Reviewing monthly provider network and recruitment activities of dental and behavioral networks
- Facilitating independent oversight by in-network providers on the Agency's Quality Management Committee of network access and availability studies conducted for primary care, specialty care, emergent care, dental, and behavioral health

To assess whether providers have reached capacity, we will use the annual PCP panel study, which includes contacting PCPs with closed panels to determine if they want to open or re-confirm they should remain closed. This study also reviews PCP panel size to determine if we have any providers not meeting our PCP-to-member ratios.

Through our Provider Access PCP Capacity policy, we can adjust a PCP panel maximum if access issues are identified for members. To the extent possible, these adjustments are performed proactively to minimize care disruption. We ask PCP to notify us in writing with 60 days' notice when they have reached 85% capacity. They must also give the same amount of notice if they intend to close their panel to Aetna Better Health members. They can notify us in writing by letter, fax, or e-mail. This information is directed to the appropriate Provider Services Representative.

We understand our providers may occasionally face challenges in balancing appointment supply or member demand under their current panel size. There is a limit to the number of patients a provider can effectively care for, and we realize that situations arise where a panel size may need to be reduced, temporarily or permanently.

Wherever possible, we will work with our contracted providers on mitigating strategies including:

- Closing the over-paneled doctor to new patients, at least temporarily
- Working with the Practice Administrator, if a provider is in a group practice, to shift more resources to support that provider or reassign members within the group
- Permanently removing members from that panel by working within our notification policies and procedures in the Aetna provider contract

Attachment 5 – Section 6.2, Question 2 [SOW 6.2.3.1]

Describe your strategies for provider outreach and contracting in rural areas.

Strategies for provider outreach

We will work with our commercial counterparts who have been health care allies since 1985 to expand our presence Iowa. Aetna Better Health will continue our efforts to secure mutually beneficial relationships with Iowa's premier health systems, which will include valued-based solutions to reward them for quality outcomes. Please reference our response to Attachment 5, Section 6.1 for provider outreach efforts currently underway; Attachment 5, Section 6.1.6, Question 1 for our provider services and communications strategy; and our response to Attachment 5, Section 6.1, Question 2 for our strategy to address network development challenges.

Provider Services will collect and analyze provider seminar evaluations to evaluate the effectiveness of outreach efforts, and information we present. Ongoing monitoring of use of the provider portal will help us assess communication effectiveness. Aetna Better Health will conduct annual provider surveys to evaluate improvements that we can make to our provider communications and other systems. Our respective Quality Improvement committees will review these surveys and develop action plans per the results of the surveys. We will share the results of surveys and improvement action plans with our Quality Management Committee.

UTILIZING FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

Pioneer in Fully Integrated Care

To make certain that our rural members have access to care, we will contract with FQHCs and RHCs, both provider-based and independent. We will allow FQHC and RHC clinics to participate as PCPs, streamlining the care coordination and information transfer process between FQHCs, RHCs, and the PCP. All our contracted FQHCs and RHCs will have signed agreements to function as PCPs for our members. We are developing policies and protocols for coordinating care and transferring information between the provider and the member's PCP.

WORKING WITH OUT-OF-NETWORK PROVIDERS

Although we are building our networks with the member's access needs in mind, we understand that provider gaps will exist and some members will be in the care or require the care of providers outside of our network. Likewise, for some of our members, critical providers may be outside of our network and we work with them to preserve the referral patterns.

If medically necessary covered services are unavailable through a participating provider, we will arrange immediate access to out-of-network providers. Our Medical Management team will authorize services to an out-of-network provider and facilitate transportation. We will not disrupt a member's ongoing course of treatment. Our Member Services, Medical Management, and Provider Services departments will work collaboratively and efficiently to:

- Contact the member or provider
- Authorize care through an executed SCA
- Attempt to contract with that provider to bring them into our network

In some instances, specialized out-of-network care may require helping the member and their family with transportation, arranging care across state lines, and arranging for follow-up appointments. We have processes in place to make this process simplified for both the member and the provider.

WHEN GETTING IMMEDIATE CARE MEANS CROSSING STATE LINES

Through Aetna's multiple year agreements and established relationships with the contiguous states of Illinois, Missouri, and Nebraska for managed Medicaid, we have extensive experience in understanding needs for provider network development in rural areas. We understand that for many of our members, the closest care could be in the next state.

Even though the preference is to contract with Iowa-based providers, we will contract with key providers within the contiguous states to provide continuity in care. For example, members residing in Southwestern Iowa have a two-hour commute to Des Moines when care is not available within their own county. These members will be able to access care in the Omaha area with only a 30 minute commute. We will provide every member transportation services to facilitate access to care. The same would be available with providers in the Quad City area with Illinois providers.

Out-of-state contracted providers and non-contracted providers are treated to the same level of responsive customer service and support as their in-state colleagues. This is especially true of our Care Management and Service Coordination teams that work closely with members and providers to arrange for specialized care, transportation, follow-up care, and other considerations.

Attachment 5 – Section 6.2, Question 3 [SOW 6.2.4, 6.2.4.1, 6.2.4.1.1, 6.2.4.1.2, 6.2.4.1.3]

Detail any way in which you propose to limit members to in-network providers.

Encouraging use of in-network providers

Aetna Better Health will not prohibit use of an out-of-network provider for medically necessary issues, or if access to care is not available within a reasonable distance or timeframe.

However, we will strongly encourage our members to use in-network providers, specifically as their PCPs. Our Member Services Representatives will assist members in finding an in-network provider that meets their cultural preferences and is within the required access standards. In the event we do not find an available network provider with a reasonable drive time, we will coordinate transportation for the member to the provider's location. We will authorize services to non-participating providers when we have exhausted all efforts to secure needed services from an in-network provider.

We will then secure an SCA with the non-participating provider and attempt to secure a full provider agreement with them so the member can continue to see the provider on a go forward basis. The SCA will bind the provider to agreed upon reimbursement terms and protect the member harmless from charges above any applicable co-payments.

Attachment 5 – Section 6.2, Question 4

Describe your plans to ensure providers do not balance bill its members and plans to work with members to help resolve billing issues.

Addressing billing requirements

Providers are contractually prohibited from balance billing. Provider Services Representatives will educate providers about the prohibition against balance billing and will address billing requirements and policies during initial orientation and at ongoing office visits. This information will also be available in our Provider Manual and on the provider portal. We will also educate our members to be aware of balance billing and how to report a provider who has balanced billed. We will monitor member complaints and take swift action against providers who balance bill members.

Provider Services Representatives will conduct onsite visits with network providers who do not follow correct billing practices and will implement corrective action. During these visits, Provider Services Representatives will:

- Determine timeframes for improvement based on the time needed to demonstrate change
- Follow up with the provider to verify that improvement milestones are met
- Report the status of this remediation plan to the Health Plan Oversight Committee
- Take all actions to alleviate any financial responsibility of the member for inappropriate billing

OPTIMIZING USE OF TIMESAVING TOOLS IMPROVES EFFICIENCY AND TRANSPARENCY

Listen, Respect, and Act with Insight, Understanding, Compassion

Providers who use the full capabilities of our provider portal will experience fewer administrative burdens, find it easier to navigate Aetna Better Health resources, and may be less tempted to resort to balance billing. With that in mind, during both orientation and throughout operations, we will promote

maximum use of our secure provider portal and WebConnect. Providers will use our secure provider portal for prior authorization submissions, claim status, electronic remittance advice, and other transactions. Providers will use WebConnect to file claims for payment. We will meet with providers individually to help them become proficient in using these tools and optimizing their functionality. Use of WebConnect also improves transparency of billing practices.

Working with members to resolve billing issues

Upon notification that a member has been billed for a covered service, our Member Services Representative will verify the member is not at fault and will not be responsible for making the payment for a covered service. In short, our message to members will be: "We will take it from here." Our Member Services Representatives will explain that providers are prohibited from billing members for any covered service other than applicable co-pays.

Member Services Representatives will work with the member to obtain details, including the date of service, amount billed, and provider's name and telephone number. They will review the member's file online to confirm all relevant information, ask the member to mail or fax us a copy of the bill, and instruct the member to not pay the bill. We will ask that the member immediately notify us of additional billing from this provider and thank the member for trusting us and taking the time to communicate about this issue. If needed, with the member on the line, the Member Services Representative may then telephone the provider to inquire about the charge; otherwise, the Member Services Representative will note the member's contact information so that we can contact the member after we have spoken with the provider.

We will track all billing or claims inquiries from members. After completing the call with the member, the Member Services Representative will research the issue using our rules-driven software application for claims payment and call tracking to determine:

- The member's enrollment status on the date of service
- Whether services provided and billed are covered
- If a claim was submitted by the provider
- Whether the amount billed is the member's cost or shared responsibility

Our Member Services Representatives will document the details of the situation in the member's file. We will use this data to measure our providers' service quality and compliance with the terms of our Contract and State and federal laws and regulations. This data will help us provide exceptional service to this and other members in the future.

If the provider did not submit the claim to us, the Member Services Representative will call the provider, give the provider the payer ID and Claims PO Box, and document the call in our call tracking system. If the provider did submit the claim, our Member Services Representative will give the provider the status of the claim. The Member Services Representative will explain to the provider that members cannot be billed for covered services. If we have denied the claim, Member Services Representative will refer the provider to remit the bill for the dispute process. The Member Services Representative will remind the provider that members cannot be billed for covered services. As necessary, we will re-train the provider regarding billing policies and procedures.

If the member has paid the provider despite our instructions, the Member Services Representative will contact the provider and request that they reimburse the member. The Member Services Representative sets a reminder to follow up with the member in 30 days to confirm that the member

received payment. If the member has not received reimbursement, the Member Services Representative notifies Provider Services to take corrective action to assist the member, upon request, with filing a grievance.

The Member Services Representative will then set a reminder to follow up with a letter to the member to explain when the bill has been resolved.

6.3 Requirements by provider type

Attachment 5 – Section 6.3, Question 1 [SOW 6.3.1]

Indicate if you will use a primary care provider (PCP) model of care delivery.

Aetna Better Health will use a PCP model of care delivery. Under this model, all members will be assigned to a PCP as their medical home and to coordinate care. Whether a member is assigned to a PCMH, to an individual PCP, or to a specialist PCP, the PCP will be contractually responsible for maintaining the centralized medical record and initiating referral to services, including behavioral health, specialty services, community-based resources, planned hospitalizations, transfer between levels of care, or referral to the long-term care system. In cases where a member has been identified as possessing a special health care need, we may assign the member to a specialist for these primary care services. When members request a change in PCP with or without cause, but in consideration of continuity of care, we screen these requests to determine if there is a resolution that can maintain the member's relationship with the provider.

Pioneer in Fully Integrated Care PCPs will act as the hub of a full care team for each member. Regardless of availability of a PCMH, FQHC, or RHC for the member, we will record the names and locations of all providers and services that the member uses to develop a care team around the member that supports holistic and coordinated care. This includes monitoring coordination and information sharing between the medical and behavioral health systems. When a member or provider contacts us with questions regarding services, referrals and authorizations, claims and utilization, or any other topic, our staff can readily answer these questions utilizing our comprehensive data system and guide materials.

PCPs must coordinate care with other providers that may also treat the member, whether within the behavioral health system, children's rehabilitative services, or another benefit program. In those geographic areas where behavioral health is not integrated, we will encourage the member's PCP to participate in a virtual Health Care Home through strong coordination and electronic health information exchange. We will provide multiple levels of Care and Case Management services for members with complex health needs as identified through predictive modeling, referral, member request, elevated contacts, or utilization review.

Attachment 5 – Section 6.3, Question 2 [SOW 6.3.1]

If a PCP model will be utilized, describe the following:

Attachment 5 – Section 6.3, Question 2.a

Physician types eligible to serve as a PCP.

The following physician types can serve as a PCP for our members: Family physicians

- General practitioners
- Internal medicine physicians
- Nurse practitioners
- Specialists with the appropriate training willing to act as a PCP
- Pediatricians

Attachment 5 – Section 6.3, Question 2.b

Any panel size limits or requirements.

We will implement the following panel size limits and requirements:

- No more than 2,500 members to one PCP
- No more than 1,000 members to one nurse practitioner
- PCPs with physician extenders may increase membership by 1,000 members per extender

Attachment 5 – Section 6.3, Question 2.c

Proposed policies and procedures to link members to PCPs.

HONORING AND ENCOURAGING OUR MEMBERS' RELATIONSHIPS WITH PCPS

Listen, Respect, and Act with Insight, Understanding, Compassion

Our members have worked hard to create functional, stable relationships with providers they trust. We will make every effort to preserve these relationships through communications, planning, and contracting with those preferred providers. For families who do not yet have an ideal provider relationship, we will work to understand the member's needs and any barriers to care with their current PCP. We will use creative methods to help the member form a cohesive relationship that leads to the best health outcomes.

All new members will receive a Provider Directory (also available online) as part of the new member welcome kit. This directory contains information on selecting providers, who is participating in the network, what providers may require referrals, and how to contact us if the member needs assistance in scheduling, transportation, or provider selection. We review provider directories and member materials for cultural competency and divide them into easily discernible topical sections to highlight information that is relevant to a specific member through call-outs, color-coding, and other design methods.

Families can self-select a PCP upon initial enrollment, during open enrollment, or if their current PCP ends his or her participation with Aetna Better Health. Members can review our provider directory and select a PCP who is accepting new members.

Pioneer in Fully Integrated Care

Central to our integrated model of care is ensuring that we pair each member with a PCP who serves the member's physical, behavioral, and cultural needs. Our PCP identification model places the member at the center of the health care delivery process. The following fundamentals will be integral to our identification process:

- Upon enrollment, all members who have not self-selected a PCP will be assigned to a PCP
- We will prioritize keeping members with their current or previous PCP on file
- If an member does not have a PCP on file, and whenever possible, we will keep families together with the same PCP
- If there is no data regarding current, past, or a family member's PCP, the member will receive a PCP assignment in accordance with the member's ZIP code to achieve a driving distance of 30 minutes or less and in accordance with the PCP's capacity to meet appointment standards

PCP changes will typically be effective the first day of the month following a request. We will educate members about this process through the Member Handbook, our website, and through our Member Services Representatives.

We permit members with special health care needs to select a specialist to act as their PCP and encourage them to make the specialist PCP part of a full care team for all services they may need. Female members may select an OB/GYN or other specialist to provide primary care. We will review the network to make certain that these providers are available in sufficient numbers.

Methods to coordinate care for members

Committed to Health Care Transformation

As we commence contract operations in Iowa, **we have one overriding objective: To positively impact the health status of the members we serve and give them the support, information, and tools they need to improve their health and manage chronic conditions**. We will work to reduce health disparities by providing needed care in the most appropriate setting and accessible format. To that end, we will leverage the special expertise and success in providing care coordination and care management services of Aetna Medicaid.

Aetna Medicaid is known for facilitating access to and coordinating the physical, behavioral, substance use disorders, and social support care for high-risk populations across many types of providers and organizations. By collaborating with members and caregivers, providers, community organizations, and state agencies, we will improve the quality of health care services for our members. With this in mind, we will implement a member-centered Care Management program that holistically integrates prevention, wellness, disease management, and specialized programs to appropriately coordinate care across an episode or continuum of care.

We understand that for many of our members, care management and disease management are what make their health care really work. These terms describe both processes and relationships. Our success in complex cases will boil down to comprehensive care management. What sets our Care Managers apart is:

- The hands-on, personal relationship they form with their members
- The sophistication behind the scenes of our care management program and technologies

For additional information regarding Care Management's role in coordinating care for members, please refer to our responses to Attachment 5, Section 9.

Attachment 5 – Section 6.3, Question 3 [SOW 6.3.1]

If a PCP model is not proposed, describe methods to ensure compliance with 42 CFR 438.208 as described in Section 6.3.1.

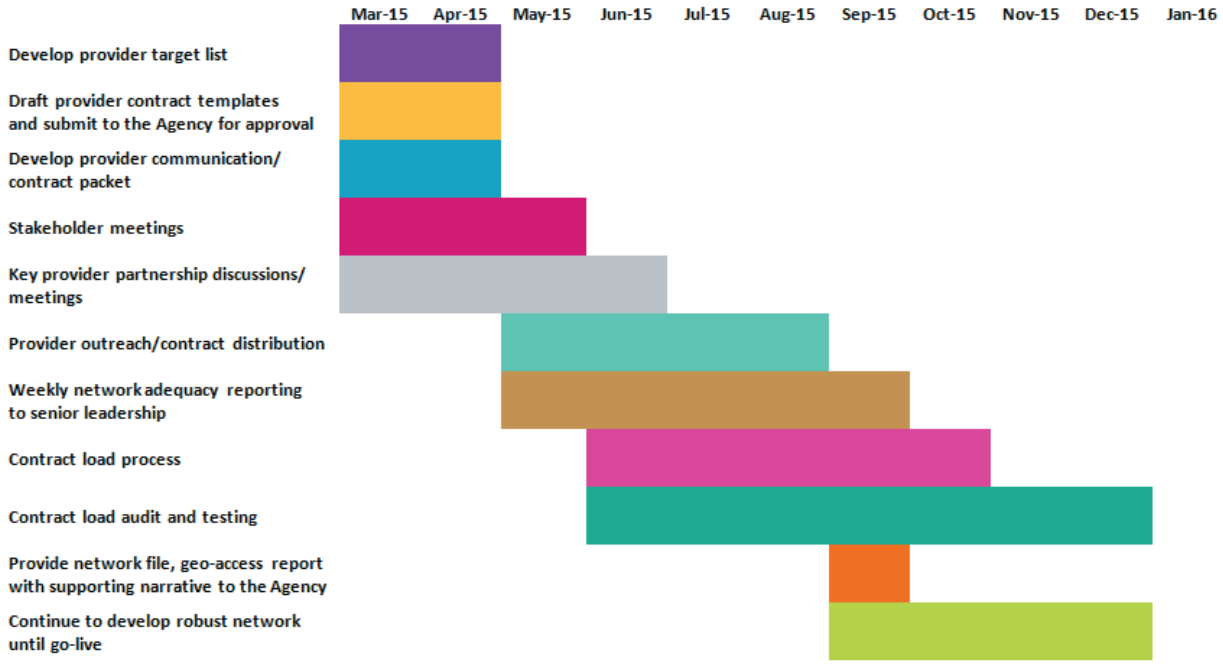
As described above, we will implement a PCP model of care in Iowa.

Attachment 5 – Section 6.3, Question 4 [SOW 6.3.2, 6.3.3, 6.3.4, 6.3.5, 6.3.6, 6.3.7, 6.3.8, 6.3.8, 6.3.9, 6.3.10, 6.3.11, 6.3.12]

Describe your plan for providing a sufficient network of all provider types outlined in Section 6.3, including timelines and tasks.

Our detailed plan, including timelines and tasks, for our Iowa provider network build is found in our Implementation Plan and response to Attachment 5, Section 2.14; this will address all provider types outlined in Section 6.3. Figure 6-4, below, summarizes this information for ease of reference and review.

Figure 6-4: Iowa Network Build Timeline



Attachment 5 – Section 6.3, Question 5 [SOW 6.3.13, 6.3.13.1, 6.3.13.2, 6.3.13.3, 6.3.13.4, 6.3.13.5, 6.3.13.6]

Describe your plans for meeting the requirements regarding Indian Healthcare Providers.

According to Census Bureau statistics, the population of American Indians and Alaska natives living in the United States totals 5.2 million. The U.S. federal government reports that more than 1 million American Indians and Alaska Natives are currently enrolled in coverage through Medicaid and CHIP (http://www.medicaid.gov/medicaid-chip-program-information/by-topics/indian-health-and-medicaid/indian-health-medicaid.html). With even more American Indians and Alaska Natives being eligible for coverage because of the Affordable Care Act's Medicaid expansion, Medicaid and CHIP can serve as a critical source of care for this community. Aetna Medicaid owns or administers plans in multiple states that have a strong American Indian and Alaska Native presence; we will draw from this experience to meet the requirements detailed in Attachment 1 of the RFP, Section 6.3.13.

Linking Indian members with Indian healthcare providers

We recognize that, historically, Indian healthcare providers have been reluctant to contract with MCOs. To mitigate this, we intend to follow the example set by our Nebraska health plan in the neighboring state:

- Targeted and comprehensive outreach efforts
- Removing barriers for members to access care from Indian healthcare providers
- Ensuring culturally competent communication with both American Indian providers and members

Listen, Respect, and Act with Insight, Understanding, Compassion

Our Community Development Manager for Aetna Better Health of Nebraska explains, "The best way to build relationships and build trust is simply by being there and showing that we care. We listen to suggestions and take them to heart in improving our product. We keep coming back." Our outreach efforts will include regular and consistent participation in tribal clinic health fairs, attending Pow Wows, and visiting providers in-person, onsite, whenever there is an event or a provider is open to meet. We will look for provider event opportunities where we can speak directly to our members or people interested in Medicaid: at these events we have the opportunity to meet support staff and other organizations in the area and hear from people wanting to know more about our health plan. Our participation in these events will include setting up an information table with educational resources and giveaway items.

We will see that brochure kiosks on reservations are updated with our information and details regarding the added benefits available through our program. Through our outreach efforts with Indian healthcare providers and Indian Health Services (IHS) in Nebraska, we have learned that our posters, brochures, and other marketing materials would have a bigger impact if they included pictures of American Indians and Alaska Natives. This is just one example of valuable feedback that we will incorporate into our outreach efforts for Iowa.

To remove barriers to care access, we will permit Aetna Better Health of Iowa members who are American Indian or Alaskan Native to receive services from a tribal clinic, Indian health Services, or any Aetna Better Health Network provider, regardless if this provider is in or out of our network without prior authorization. **All co-payments are waived and no referrals are necessary.** Both provider and member education materials, including our Provider and Member Handbooks and websites, will explain these benefits as well as an American Indian or Alaskan Native member's right to choose an Indian Health Service or tribal clinic provider as a PCP.

Our Member Service Representatives will be trained to assist members in finding an Indian healthcare provider that meets their needs and is within a reasonable driving distance. As detailed in our response to Section 6.1.4, above, providing culturally competent care to *all* members is central to our approach to delivering care. With our American Indian and Alaska Native members and providers, we understand that this is of utmost importance. We will collaborate with the Iowa American Indian tribes to understand from them the best way to communicate with them and their constituents. To learn more about these communities, we will participate in cultural trainings, attend lunch-and-learns, conferences, and listen to public speakers. We also take the time to share our knowledge with other MCOs and organizations in Iowa as well as our plans nationwide.

Ensuring prompt payments and reimbursements to Indian healthcare providers

Our policies and procedures regarding billing, reimbursement, and payment of IHS providers will be fully in compliance with the requirements set forth in Attachment 1 to the RFP: Section 6.3.13 and as mandated by Section 5006(d) of the American Recovery and Reinvestment Act of 2009. Our provider services team will be responsible for educating Indian healthcare providers to address billing and claims submission. The initial trainings will be conducted onsite at each IHS location. This information is reinforced during routine site visits and ongoing provider communications. Our policies and procedures will also be described in the Provider Manual and made available to these providers through the provider portal.

When a member is identified as American Indian or Alaskan Native, we will implement a $0 co-payment schedule. We will flag the file of our American Indian and Alaskan Native members upon enrollment, and we will provide these members an ID card showing a $0 co-pay. We will also emphasize awareness of, and promote adherence to, the $0 co-payment provision through member, staff, and provider education initiatives.

We will closely monitor our Member and Provider Services and Grievances and Appeals Departments for complaints from this population concerning these requirements. Further, we will report all payments to the Agency so that there is a record that the provider is paid the entire federal rate.

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Section 7: Enrollment

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SECTION 7 – ENROLLMENT

The table below outlines how the Scope of Work provided in RFP Attachment 1 relates to the responses to the questions provided in RFP Attachment 5. We provide this table to reduce redundancy of responses and information and to simplify the evaluation process for the evaluators.

For requirements in Attachment 1 that do not require a detailed response, the table below indicates our intent to comply with the stated requirement in lieu of repeating the RFP question and including a will comply statement within the body of the narrative.

Attachment 1 requirement	Cross reference to Attachment 5	Will comply
7.1 Eligibility	--	Yes
7.2 MCO Selection and Assignment	--	Yes
7.2.1 Current Enrollees	--	Yes
7.2.1.1 1915(c) HCBS Waiver Enrollees and Institutional Populations	--	Yes
7.2.2 New Enrollees	--	Yes
7.2.2.1 New Enrollee Plan Selection Information	--	Yes
7.2.3 Auto Assignment	--	Yes
7.3 Enrollment Discrimination	--	Yes
7.4 Member Disenrollment	Attachment 5 - Section 7.4, Question 1	Yes
7.4.1 Member Disenrollment for Cause	Attachment 5 - Section 7.4, Question 1	Yes
7.4.1.1 Cause	Attachment 5 - Section 7.4, Question 1	Yes
7.4.1.2 Process	Attachment 5 - Section 7.4, Question 1	Yes
7.4.2 Contractor Initiated Disenrollment	Attachment 5 - Section 7.4, Question 1	Yes
7.4.3 Notification of Member Death or Incarceration	Attachment 5 - Section 7.4, Question 1	Yes

General requirements

Please explain how you propose to execute Section 7 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

We will use best practices gained from our experience in other states to seamlessly enroll members in Iowa

Committed to Health Care Transformation in Iowa

Aetna Better Health of Iowa Inc. (Aetna Better Health) will draw on the best practices developed by our health plans to fulfill the requirements for RFP Attachment 1, Section 7. Our enrollment processes support the guiding principles of the Iowa Department of Human Services (the Agency): Connecting members to health care homes, attending to the wellness of each member, and emphasizing each member's needs. Our goal is to make the enrollment process as seamless as possible through strong working relationships with both the Agency and the enrollment broker.

We have extensive experience enrolling members in Medicaid-eligible categories, including physical health, behavioral health, and long-term care, including 1915(c) HCBS waiver programs and individuals residing in institutions or nursing facilities. We have conducted successful eligibility and enrollment implementations in 17 states and have the people, processes, and tools to support eligibility in Iowa. Our health plans enroll members through the auto-assignment process and have worked with states where the member auto-assignment algorithm depends on plan performance, quality outcomes, and member satisfaction.

Our health plans enroll dual eligible members in Arizona, Michigan, Ohio, Illinois, and New York. We have the depth and experience to process and reconcile State and CMS data across various dual demonstrations.

Our health plans are successful in working with the State and CMS through the implementation dual demonstrations and have built a strong understanding of the processes.

One example of how one of our health plans successfully managed large-scale enrollment is in Kentucky. In recent years, the health plan faced the daunting challenge of adding 68,000 members from a retreating managed care organization in the single minute between 11:59 p.m. on July 5 and midnight on July 6. The plan coordinated their new members' needs by loading enrollment, mailing member ID cards, answering member and provider calls, conducting reviews, and issuing prior authorizations in record time.

By the end of the initial transition period, the Kentucky health plan:

- Completed 1,100 case management outreach contacts
- Identified 83 high-risk obstetrics members
- Initiated a full medical review for members with organ transplants
- Managed 50 behavioral health transitions of care and transition of care for all members impacted by pharmacy prior authorization requirements
- Withstood a 50% surge in fax and call volumes during the first few days

They credit their success to one guiding principle: "What does this mean for the member who needs health care services?"

Member transition: A focus on uninterrupted care

Our processes develop long-lasting relationships to increase member satisfaction and retention. We specifically address the concerns of members who are new to managed care and who often have a number of common questions the first month of enrollment, ranging from basic questions on benefit coverage to assistance with changing primary care providers (PCPs).

Before a contract's implementation date, it is important for us to work with the Agency to complete a thorough testing of our enrollment process. In our experience, a strong collaboration between the managed care organization, the Agency, and the enrollment broker goes a long way to creating the best member experience. This focus on relationship building sums up our core value: Collaboration to produce results. We are delighted to work with the Agency to provide a smooth enrollment process for all members.

A critical step during the implementation of a new health plan is to provide accuracy of our benefit enrollment and maintenance (834) file data. This data includes eligibility, special needs indicators, and demographics information and must be as accurate and current as possible to reduce any barriers to care, such as mail delays, returned mail, or difficulty making member contact.

Our recommended approach for ensuring maximum accuracy and a great member experience:

1. We report data discrepancies to the Agency.
2. The Agency or enrollment broker updates their system to reflect the most current data.
3. We upload accurate 834 file data into our system.

Enrollment for all eligible categories

The enrollment process begins when the Agency sends us enrollment information and ends when each member has a PCP assignment, member packet, and member ID card. During every step, we will confirm we have correct data and we will handle and resolve any discrepancies.

Our Enrollment Manager takes a comprehensive look at the enrollment file data and allows us to process data on time and accurately. We work consistently with our shared services departments and vendors to optimize enrollment processing and maintenance. Aetna Better Health will enroll the following categories of members as listed in Exhibit C of the contract. These categories are:

- American Indian/Alaskan Native
- Individuals with breast or cervical cancer
- Children under 19
- Children in foster care, subsidized adoptions, or guardianship
- Family Planning Waiver
- Former foster children
- hawk-i
- Home and community-based services
- Iowa Department of Public Health participants
- Independent foster care adolescents
- Infants under the age of 1
- Institutionalized
- Iowa Health and Wellness Plan
- Children with special needs
- Medically needy (with and without spend-down)
- Medicaid for Employed People with Disabilities
- Non IV-E adoption assistance
- Parents and other caretakers
- Pregnant women
- Presumptively eligible populations
- Supplemental Security Income recipients
- State supplementary assistance
- Traditional medical assistance

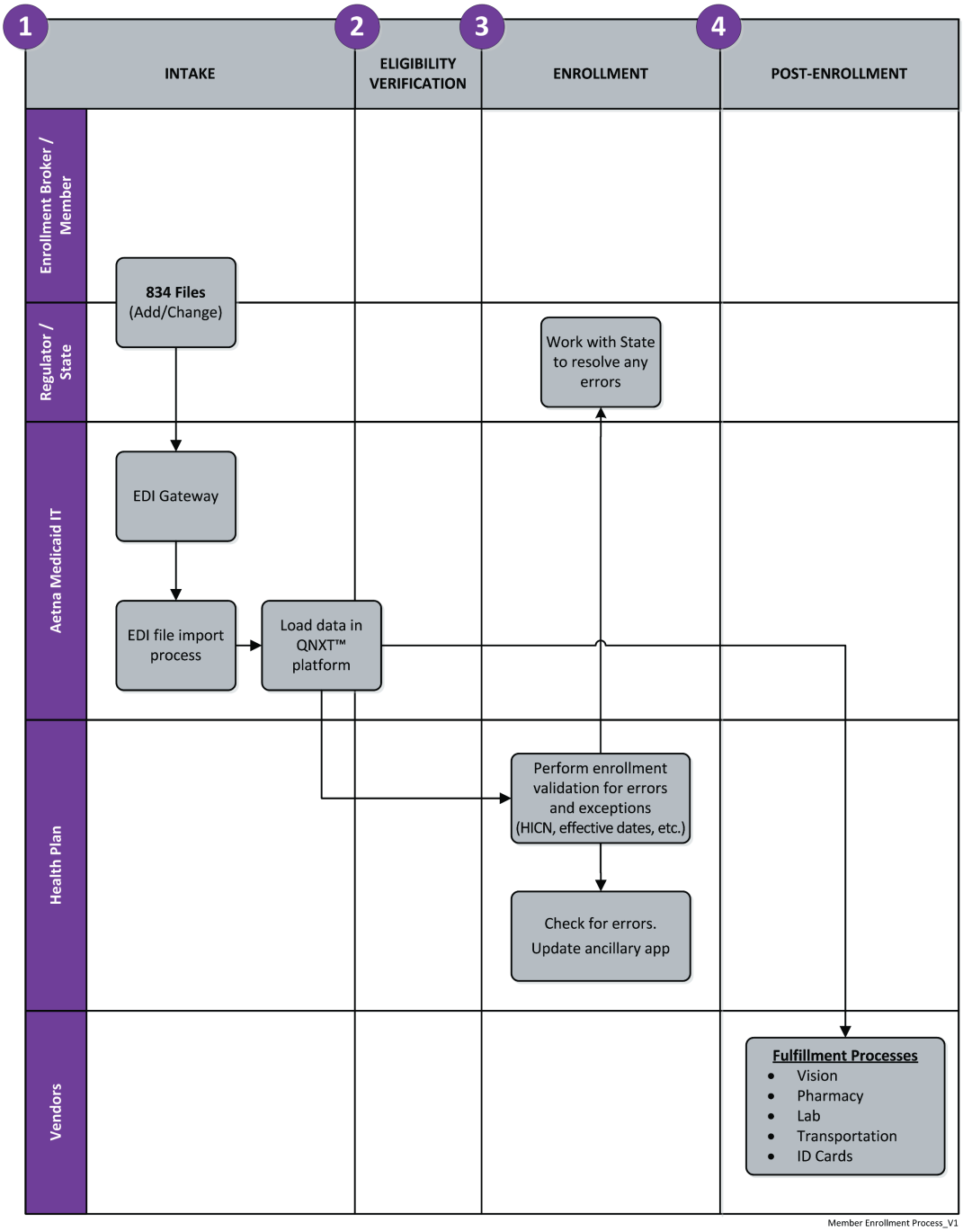
Enrollment procedures and tools

When we receive daily, weekly, or monthly eligibility files from the Agency, the data transfer happens through our Electronic Database Interchange (EDI). The EDI receives, tracks, and loads the data files into QNXT™, our business application and data management system. It is the center of Aetna Medicaid's application architecture and houses current provider contracts, claims, member eligibility, authorization, and concurrent review data.

We will validate and process members' enrollment promptly. Our Enrollment Services Representatives will verify member eligibility for each health plan policy. After we load the files into QNXT™, the Enrollment Services Department will validate the data by confirming accuracy of enrollment, demographics, and other fields specific to health plan policies. Enrollment Services will perform daily, weekly, and monthly audits to verify the accuracy of members' enrollment records in our system. The audits compare the Agency's eligibility file to QNXT™ and capture any discrepancies between the data sets. The Enrollment Services Representatives make the necessary changes to QNXT™, working with the Agency as needed to verify and correct the data. When we receive data from the Agency, the system may identify some member information as having errors; we will review and correct those errors manually. Our Enrollment Services staff will work with the Agency to investigate these exceptions and confirm the necessary corrections. Figure 7-1 illustrates our standard enrollment process.

Figure 7-1: Our process for receiving, processing, and updating member enrollment

- Enrollment files would be processed as per the State's contract requirements
- Typically, daily enrollment files would be processed within 1 day of file receipt from the Regulator/Enrollment Broker and monthly reconciliation enrollment files on an average of 3-5 days of file receipt



ACCURATE AND THOROUGH ENROLLMENT FILE INTAKE AND RECONCILIATION

Quality and Value through Simple, Relevant Solutions

We have applied their best practices of enrollment of various eligibility categories. For example, for the member reconciliation process, our health plans continually work with the states they serve to reduce the error rate.

While our goal is to enroll members the right way the first time, our process also fully addresses errors and discrepancies. We will generate a daily error report if the data does not match the rules set by Iowa Medicaid enrollment. We will set up rules and perform manual reconciliation if needed. Our turnaround time for daily files is one business day; monthly reconciliations are five business days. This error report management process has streamlined our activities and helps reduce negative downstream effects for other functional areas such as Member Services, Case Management, and others.

We will validate enrollment data and work directly with the Agency in the event of discrepancies. We will report all discrepancies to the Agency under the required timeframe and process. We will use business content and market intelligence tools to improve member data. Reliable data will allow us to maintain updated member demographics.

We will perform a weekly internal audit of our Enrollment Services Representatives, randomly auditing transactions and reviewing 25 to 30 fields. For seasoned Enrollment Services Representatives, we will audit 10 transactions. For new hires, we will audit 100% of the work. We require a 98% accuracy rate. If the Enrollment Services Representative does not meet the passing criteria, we will increase the amount of transactions audited. We identify trends and will provide training opportunities for the Enrollment Services Representative, as needed, and we will perform audits on our fulfillment vendors' files.

PCP SELECTION AND ASSIGNMENT

We will give members the opportunity to select a PCP upon enrollment. If a member does not select a PCP, we will assign one by considering factors such as language, location, and special needs. If we automatically assign the provider, the member may request a PCP change upon notification of the PCP assignment. We will make a list of PCPs available to all members and Member Services Representatives will be available to assist members with PCP selection. We will give members the freedom to select participating PCPs within applicable age limit restrictions. We encourage members to choose a geographically convenient PCP but do not restrict members based on geography.

NEWBORN ENROLLMENT: A SMOOTH START FOR NEW BEGINNINGS

Three Decades of Caring for Those Most Vulnerable

Our Aetna Better Health plans have extensive experience with newborn enrollment. Our plan in Maryland enrolled approximately 26,000 newborns between 2010 and 2014. For the enrollment of a newborn, we will provide a temporary ID and match that ID with the mother's ID or any other field. This seamless and unique process allows us to track and identify our members in our system. Our goal is to streamline access to health care services for mothers and newborns through daily communications between our enrollment staff and the Agency.

To expedite timely enrollment, we will train our local enrollment staff on the newborn enrollment process. Our newborn-focused staff, enabled by our enrollment business application, will quickly identify newborns by date of birth. We will then link newborn records to eligibility and enrollment data when we receive data from the Agency. Our manual enrollment process for all newborns will help

prevent duplicate records and verify the links between each newborn and the newborn's family member or members.

Upon notification of a birth, our enrollment staff will create an active, temporary account in our enrollment business application. We will then link the temporary account to the mother's account by using the mother's ID number, preceded by the designator *NB*. The newborn has immediate coverage and will be authorized under the temporary account until we receive a unique ID number for the newborn. We also use a manual process for newborn enrollment, both before and after we receive the permanent ID. This process allows us to provide prior authorizations quickly.

There are many sources from which we receive notice of a birth, including:

- **The newborn's parent** – The pregnant member has the first opportunity to make the notification; instructions in the Member Handbook alert members of the importance of contacting us as soon as possible during the pregnancy and upon delivery.
- **Hospital staff** – After we learn of a pregnancy from hospital staff, our Case Managers contact the member to review available services and identify the potential of a high-risk pregnancy or delivery. If we identify a member as high-risk, we follow her throughout the pregnancy and know immediately when she delivers. If the member presents little or no risk, we call her during each trimester to determine whether there are any new risks that may warrant Care Management services. We inquire about the due date and document the date in our Care Management system.
- **Concurrent Review staff** – Concurrent Review staff notify us of any non-routine deliveries. Our provider contracts require that hospitals notify us of any hospital admissions for our members, including those resulting in a birth.

7.4 Member disenrollment

Attachment 5 – Section 7.4, Question 1 [SOW 7.4, 7.4.1, 7.4.1.1, 7.4.1.2, 7.4.2, 7.4.3]

Describe your grievance process for addressing member quality of care concerns and member disenrollment after the first ninety (90) days of enrollment.

Our grievance process for member quality of care concerns

It is our intent and mission to provide the highest quality of care to our members and support our members' health and well-being. If a member is dissatisfied with the quality of care provided by our staff, network providers, or sub-contractors, we take their concerns very seriously.

We will provide member education through multiple channels on their right to file a grievance with us, we will provide them thorough and accurate information regarding grievance processes and procedures, and we will communicate with them respectfully, catering to their individuality.

Listen, Respect, and Act with Insight, Understanding, Compassion

Member Advocates, Case Management, Long Term Services and Supports (LTSS) Case Management, and Field Base Case Management can make interventions to address member issues. We work with members to meet their needs by communicating with them and all necessary internal departments to alleviate any issues they might experience.

Our member-facing staff will complete role-specific training on how to document any quality of care issues received as part of a grievance or identified through our interactions with members. When we receive a quality of care concern, the Grievance and Appeal Department immediately begins the investigation process by completing the Potential Quality of Care (PQoC) Concerns Investigations form in the Aetna enterprise-wide Quality of Care database. This automated system routes the form to the local Quality Management staff for investigation. Documenting all quality of care concerns, regardless of how they are received, allows our Quality Management Department to identify any trends.

Our integrated quality review process ensures that issues involving quality of care or service, safety, complaints, or other areas of dissatisfaction receive fitting consideration. We require any staff who perceives a potential quality, risk management, or safety issue to follow the four-step process listed below:

1. **Refer –** Functional departments such as Case Management, Utilization Management, Compliance, Grievance and Appeal, or Member Services will refer the issue to the Quality Management Department.
2. **Document –** That functional department will document the issue on a PQoC Concerns Investigations form and forward the form to the Quality Management Department for evaluation.
3. **Review –** Quality Management Nurses may review and assign a different functional area within the organization to review and address the needs as indicated; for example, Provider Relations.
4. **Track –** The Quality Management staff will document and track potential quality of care issues in the PQoC business applications system.

The Chief Medical Officer or designated Medical Director will oversee peer review investigations and follow the quality review by:

- Determining quality of the care and services through concurrent or retrospective evaluation of medical records
- Referring potential issues to the Quality Management/Utilization Management (QM/UM) Committee or our Credentialing and Performance Committee for review and recommendation
- Notifying the Board of Directors indicating the decision and course of action rendered by the Credentialing and Performance Committee.
- Analyzing identified issues, tracking and trending
- Reporting findings quarterly
- Notifying appropriate regulatory boards or agencies on provider contract termination, suspension, or other
- Developing and implementing corrective action plans as necessary
- Providing fair hearing right to practitioners

Indicators used to identify potential quality, risk management, and safety issues are specific to Aetna Better Health and approved by the QM/UM and Quality Management Oversight Committees.

SUPPORTING THE GRIEVANCE PROCESS

Members or their representatives will be able to file a grievance directly with us in writing (e-mail, facsimile, or U.S. mail), verbally through the toll-free Member Services number, or to any health plan staff member. We do not take punitive action against a provider for acting on a member's behalf in filing a grievance. We will follow the timelines of an expedited grievance.

To help members navigate the process, our Member Services Representatives and Grievance System staff will provide assistance by explaining the process and forms and completing forms. We will provide interpreter services and alternate formats as needed at no cost to the member. If a member requests assistance, we will assign a staff member to help the member throughout the grievances process.

We view disenrollment as a last resort, only after we have exhausted all other interventions. If the member remains dissatisfied with the outcome, we will guide the member to the enrollment broker to request disenrollment. We will provide a copy of the member's grievance record to the enrollment broker to allow the enrollment broker to render a recommendation for our review regarding approval or denial of the disenrollment request. The effective date of the disenrollment will be no later than the first day of the second month following the month in which the member files the request. If the enrollment broker fails to make a disenrollment determination within the timeframes specified, the disenrollment is considered approved.

For more details regarding our Grievance, Appeal, and State Fair Hearing process, please refer to our response to Section 8.15.

SERVICE IMPROVEMENT COMMITTEE

We will institute a Service Improvement Committee (SIC) to serve our members better. The SIC will advise and make recommendations to the Quality Management Oversight Committee or our management about customer (member and provider) issues. The committee is comprised of our Chief Operation Officer (Chairperson), Chief Medical Officer, representatives from our Member Services, Provider Services, Medical Management, Quality Management, and Grievance and Appeals Departments, and other selected staff as required. SIC's responsibilities are to:

- Review and evaluate issues regarding any trending of member and provider complaints, grievances, and appeals and make recommendations
- Review, evaluate, and make recommendations about operational measures (such as prior authorization time standards, claims payment standards, customer service time standards, and member enrollment and disenrollment reconciliation)
- Review, evaluate, and make recommendations about compliance with standards for claim reporting
- Review reports from the Stakeholder Advisory Board and recommend action

The SIC will meet quarterly. We will document the minutes and keep them in a safe, confidential, and protected file in the Member Services Department. We will provide summary reports to the Quality Management Oversight Committee and the Aetna Better Health Board of Directors.

Addressing member disenrollment

Do the Right Thing
for the Right Reason

Per Title 42 of the CFR § 438.56(c), *Disenrollment requested by the member*, members may disenroll without cause during the first 90 days of initial enrollment. Members may also request disenrollment when the Agency imposes the intermediate sanction specified in 42 CFR 438.702(a)(3). Disenrollment provisions will apply regardless of mandatory or voluntary enrollment. Following this 90-day period and prior to the next enrollment period, the member may request disenrollment from our plan if:

- The member moves out of the service area
- We do not cover the services the member is seeking due to moral or religious objections

- A member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the member's provider determines that receiving the services separately would subject the member to unnecessary risk
- A provider disenrolls and this disenrollment would result in disruption to the member's residence or employment
- There are other reasons such as poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs

We will attempt to resolve any difficulties with the member through education, care management, and other interventions. Our most important technique is to listen to our members and to address their individual needs, integrating their valuable insight to help all members have a more positive experience.

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Section 8: Member Services

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SECTION 8 – MEMBER SERVICES

The table below outlines how the Scope of Work provided in RFP Attachment 1 relates to the responses to the questions provided in RFP Attachment 5. We provide this table to reduce redundancy of responses and information and to simplify the evaluation process for the evaluators.

For requirements in Attachment 1 that do not require a detailed response, the table below indicates our intent to comply with the stated requirement in lieu of repeating the RFP question and including a will comply statement within the body of the narrative.

Attachment 1 Requirement	Cross reference to Attachment 5	Will comply
8.1 Marketing		Yes
8.1.1 Marketing Activities	Attachment 5 - Section 8.1, Question 1	Yes
8.1.1.1 Permissible Marketing Activities	Attachment 5 - Section 8.1, Question 1	Yes
8.1.1.2 Prohibitions on Marketing to Potential Members	Attachment 5 - Section 8.1, Question 1	Yes
8.1.1.3 General Marketing Prohibitions	Attachment 5 - Section 8.1, Question 1	Yes
8.2 Member Communications	Attachment 5 - Section 8.2, Questions 1,2,3,4,5	Yes
8.2.1 General	Attachment 5 - Section 8.2, Question 1	Yes
8.2.2 Language Requirements	Attachment 5 - Section 8.2, Question 2	Yes
8.2.3 Alternative Formats	Attachment 5 - Section 8.2, Question 3	Yes
8.2.4 State Review and Approval of Member Communications	Attachment 5 - Section 8.2, Question 4	Yes
8.2.5 Policies and Procedures	Attachment 5 - Section 8.2, Question 4	Yes
8.2.6 New Member Communications	Attachment 5- Section 8.2, Question 5	Yes
8.2.6.1	Attachment 5 - Section 8.2, Question 5	Yes
8.2.6.2	Attachment 5 - Section 8.2, Question 5	Yes
8.2.6.3	Attachment 5 - Section 8.2, Question 5	Yes
8.2.6.4	Attachment 5 - Section 8.2, Question 5	Yes
8.2.6.5	Attachment 5 - Section 8.2, Question 5	Yes
8.2.6.6	Attachment 5 - Section 8.2, Question 5	Yes
8.2.6.7	Attachment 5 -Section 8.2, Question 5	Yes
8.2.6.8	Attachment 5 -Section 8.2, Question 5	Yes
8.2.6.8.1	Attachment 5 -Section 8.2, Question 5	Yes
8.2.6.8.2	Attachment 5 -Section 8.2, Question 5	Yes
8.2.6.9	Attachment 5 -Section 8.2, Question 5	Yes
8.2.6.10	Attachment 5 -Section 8.2, Question 5	Yes
8.2.6.11	Attachment 5 -Section 8.2, Question 5	Yes
8.2.6.12	Attachment 5 -Section 8.2, Question 5	Yes
8.2.6.13	Attachment 5 -Section 8.2, Question 5	Yes
8.2.6.14	Attachment 5 -Section 8.2, Question 5	Yes
8.2.6.15	Attachment 5 -Section 8.2, Question 5	Yes
8.2.6.16	Attachment 5 -Section 8.2, Question 5	Yes
8.2.6.17	Attachment 5 -Section 8.2, Question 5	Yes
8.2.6.18	Attachment 5 -Section 8.2, Question 5	Yes
8.2.6.19	Attachment 5 -Section 8.2, Question 5	Yes
8.2.6.20	Attachment 5 -Section 8.2, Question 5	Yes

Attachment 1 Requirement	Cross reference to Attachment 5	Will comply
8.2.6.21	Attachment 5 -Section 8.2, Question 5	Yes
8.2.6.22	Attachment 5 -Section 8.2, Question 5	Yes
8.2.6.23	Attachment 5 -Section 8.2, Question 5	Yes
8.2.6.23.1	Attachment 5 -Section 8.2, Question 5	Yes
8.2.6.23.2	Attachment 5 -Section 8.2, Question 5	Yes
8.2.6.23.3	Attachment 5 -Section 8.2, Question 5	Yes
8.2.7 Right to Request and Obtain Information	Attachment 5 - Section 8.2, Question 2	Yes
8.2.8 Notification of Significant Change	Attachment 5 - Section 8.2, Question 6	Yes
8.2.8.1	Attachment 5 - Section 8.2, Question 6	Yes
8.2.8.2	Attachment 5 - Section 8.2, Question 6	Yes
8.2.8.3	Attachment 5 - Section 8.2, Question 6	Yes
8.2.8.4	Attachment 5 - Section 8.2, Question 6	Yes
8.2.8.5	Attachment 5 - Section 8.2, Question 6	Yes
8.2.8.6	Attachment 5 - Section 8.2, Question 6	Yes
8.2.8.7	Attachment 5 -Section 8.2, Question 6	Yes
8.2.8.8	Attachment 5 -Section 8.2, Question 6	Yes
8.2.8.9	Attachment 5 - Section 8.2, Question 6	Yes
8.3 Member Services Helpline	Attachment 5 - Section 8.3, Questions 1,2	Yes
8.3.1 Availability for All Callers	Attachment 5 - Section 8.3, Question 3	Yes
8.3.2 Helpline Staff Knowledge	Attachment 5 - Section 8.3, Question 4	Yes
8.3.3 Helpline Performance Metrics	Attachment 5 - Section 8.3, Question 5	Yes
8.3.4 Backup System	Attachment 5 - Section 8.3, Question 6	Yes
8.3.5 Integration of Service Lines	Attachment 5 - Section 8.3, Question 7	Yes
8.3.6 Tracking and Reporting	Attachment 5 - Section 8.3, Question 2	Yes
8.4 Nurse Call Line	Attachment 5 - Section 8.4, Questions 2,3	Yes
8.5 Electronic Communications	Attachment 5 - Section 8.5, Questions 1,2,3	Yes
8.6 Member Website	Attachment 5 - Section 8.6, Question 1	Yes
8.7 Health Education and Initiatives	Attachment 5 - Section 8.7, Question 1	Yes
8.7.1 Example Programs	Attachment 5 - Section 8.7, Question 1	Yes
8.7.1.1	Attachment 5 - Section 8.7, Question 1	Yes
8.7.1.2	Attachment 5 - Section 8.7, Question 1	Yes
8.7.1.3	Attachment 5 - Section 8.7, Question 1	Yes
8.7.1.4	Attachment 5 - Section 8.7, Question	Yes
8.7.1.5	Attachment 5 - Section 8.7, Question	Yes
8.7.1.6	Attachment 5 - Section 8.7, Question	Yes
8.7.1.7	Attachment 5 - Section 8.7, Question	Yes
8.7.1.8	Attachment 5 - Section 8.7, Question	Yes
8.7.1.9	Attachment 5 - Section 8.7, Question	Yes
8.7.1.10	Attachment 5 - Section 8.7, Question	Yes
8.7.1.11	Attachment 5 - Section 8.7, Question	Yes
8.7.1.12	Attachment 5 - Section 8.7, Question	Yes
8.8 Cost and Quality Information	Attachment 5-Section 8.8, Questions 1,3	Yes
8.8.1 Explanation of Benefits	Attachment 5- Section 8.8, Questions 2	Yes
8.8.2 Quality Information	Attachment 5 - Section 8.8, Questions 3	Yes
8.9 Advance Directive Information		Yes

Attachment 1 Requirement	Cross reference to Attachment 5	Will comply
8.9.1 Policies and Procedures		Yes
8.9.2 Member Notification		Yes
8.10 Member Rights	Attachment 5 - Section 8.10, Question 1	Yes
8.10.1 Receipt of information	Attachment 5 - Section 8.10, Question 1	Yes
8.10.2 Dignity and privacy	Attachment 5 - Section 8.10, Question 1	Yes
8.10.3 Receive information on available treatment options	Attachment 5 - Section 8.10, Question 1	Yes
8.10.4 Participate in decisions	Attachment 5 - Section 8.10, Question 1	Yes
8.10.5 Freedom from restraint or seclusion	Attachment 5 - Section 8.10, Question 1	Yes
8.10.6 Copy of medical records	Attachment 5 - Section 8.10, Question 1	Yes
8.10.7 Treatment setting	Attachment 5 - Section 8.10, Question 1	Yes
8.10.8 Community participation	Attachment 5 - Section 8.10, Question 1	Yes
8.10.9 Health care services	Attachment 5 - Section 8.10, Question 1	Yes
8.11 Redetermination Assistance	Attachment 5 - Section 8.11, Question 1	Yes
8.11.1 Permissible Activities	Attachment 5 - Section 8.11, Question 1	Yes
8.11.2 Prohibited Activities	Attachment 5 - Section 8.11, Question 1	Yes
8.12 Member and Stakeholder Engagement	Attachment 5 - Section 8.12, Question 1	Yes
8.12.1 Stakeholder Advisory Board	Attachment 5 - Section 8.12, Question 2	Yes
8.12.1.1 Advisory Board Plan	Attachment 5 - Section 8.12, Question 2	Yes
8.12.1.2 Advisory Board Composition	Attachment 5 - Section 8.12, Question 2	Yes
8.12.1.3 Documentation	Attachment 5 - Section 8.12, Question 2	Yes
8.12.1.4 Facilitating Member Participation	Attachment 5 - Section 8.12, Question 3	Yes
8.12.1.5 Meeting Frequency	Attachment 5 - Section 8.12, Question 3	Yes
8.12.1.6 Meeting Outcomes	Attachment 5 - Section 8.12, Question 3	Yes
8.13 Stakeholder Education	Attachment 5 - Section 8.13, Questions 1,2	Yes
8.14 Implementation Support	Attachment 5 - Section 8.14, Question 1	Yes
8.15 Grievances, Appeals, and State Fair Hearings	Attachment 5 – Section 8.15, Question 1	Yes
8.15.1 General	Attachment 5 – Section 8.15, Question 1	Yes
8.15.2 Appeals	Attachment 5 – Section 8.15, Question 1	Yes
8.15.3 Grievances	Attachment 5 – Section 8.15, Question 1	Yes
8.15.4 State Fair Hearings	Attachment 5 – Section 8.15, Question 1	Yes
8.15.5 Contractor Appeal Policies	Attachment 5 – Section 8.15, Question 1	Yes
8.15.5.1 Filing a Grievance or Appeal	Attachment 5 – Section 8.15, Question 1	Yes
8.15.5.2 General Process for Appeals	Attachment 5 – Section 8.15, Question 1	Yes
8.15.5.3 Staff Processing Requirements	Attachment 5 – Section 8.15, Question 1	Yes
8.15.5.4 Expedited Appeals	Attachment 5 – Section 8.15, Question 1	Yes
8.15.5.5 Appeals Processing Timeline Requirements	Attachment 5 – Section 8.15, Question 1	Yes
8.15.5.5.1	Attachment 5 – Section 8.15, Question 1	Yes
8.15.5.5.2	Attachment 5 – Section 8.15, Question 1	Yes
8.15.5.5.3	Attachment 5 – Section 8.15, Question 1	Yes
8.15.5.5.4	Attachment 5 – Section 8.15, Question 1	Yes
8.15.5.5.5	Attachment 5 – Section 8.15, Question 1	Yes
8.15.5.5.6	Attachment 5 – Section 8.15, Question 1	Yes
8.15.5.5.7	Attachment 5 – Section 8.15, Question 1	Yes
8.15.6 State Fair Hearing Process	Attachment 5 – Section 8.15, Question 1	Yes

Attachment 1 Requirement	Cross reference to Attachment 5	Will comply
8.15.6.1	Attachment 5 – Section 8.15, Question 1	Yes
8.15.6.2	Attachment 5 – Section 8.15, Question 1	Yes
8.15.6.3	Attachment 5 – Section 8.15, Question 1	Yes
8.15.6.4	Attachment 5 – Section 8.15, Question 1	Yes
8.15.6.5	Attachment 5 – Section 8.15, Question 1	Yes
8.15.7 Continuation of Benefits Pending Appeal & Reinstatement of Benefits	Attachment 5 – Section 8.15, Question 1	Yes
8.15.7.1	Attachment 5 – Section 8.15, Question 1	Yes
8.15.7.2	Attachment 5 – Section 8.15, Question 1	Yes
8.15.7.3	Attachment 5 – Section 8.15, Question 1	Yes
8.15.7.4	Attachment 5 – Section 8.15, Question 1	Yes
8.15.8 Notices of Action & Grievance, Appeal and Fair Hearing Procedures	Attachment 5 – Section 8.15, Question 1	Yes
8.15.8.1	Attachment 5 – Section 8.15, Question 1	Yes
8.15.8.2	Attachment 5 – Section 8.15, Question 1	Yes
8.15.8.3	Attachment 5 – Section 8.15, Question 1	Yes
8.15.8.4	Attachment 5 – Section 8.15, Question 1	Yes
8.15.8.5	Attachment 5 – Section 8.15, Question 1	Yes
8.15.8.6	Attachment 5 – Section 8.15, Question 1	Yes
8.15.8.7	Attachment 5 – Section 8.15, Question 1	Yes
8.15.8.8	Attachment 5 – Section 8.15, Question 1	Yes
8.15.9 Exception to Contractor Policy Process	Attachment 5 – Section 8.15, Question 2	Yes

8.1 Marketing

Please explain how you propose to execute Section 8 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

The goals of our marketing and member education plan are to establish visual recognition of Aetna Better Health of Iowa Inc. (Aetna Better Health) in the community and gain recognition as a trusted ally. Our Marketing and Member Services operations will adhere to the rules and regulations set forth for the Iowa High Quality Healthcare Initiative (the Initiative) with the Iowa Department of Health Services (the Agency).

We are building an infrastructure of support by advancing our understanding of the environment and the unique needs of the communities we will serve:

- **A local plan** – Our business development team has been on the ground in Iowa to meet with community organizations and engage local resources. We will use this valuable local feedback to tailor our marketing and community outreach programs to meet the needs of Iowans. We will recruit and hire Iowa-based Outreach and Member Services staff who are knowledgeable of the unique needs of the communities we will serve.
- **A focus on accessibility for our members** – Our 24/7 Member Services Helpline and Nurse Call Line will help us connect with our members at any time of the day or night. By offering this service, we connect to Iowans who need immediate support—parents who have a sick child at home in the middle of the night, or members who are unsure of whether they should go to the Emergency Department (ED). We want to be there for our members any time they need us.

- **Innovative member engagement** – Our member portal and mobile application will give Iowans valuable tools to take an active role in their health decisions. Through these tools, members can view personal health records, access health alerts, get reminders for tests, and find providers in our network.

Aetna brings a long history of outreach and a commitment to local communities. In 2014, Aetna Inc. (our parent company) and the Aetna Foundation awarded more than $20 million in grants to non-profits, academic institutions, and other organizations across the country. These grants focus on improving nutrition and increasing physical activity; promoting equity in health and health care for chronic conditions; building a more diverse generation of health care professionals; and exploring innovative solutions to promote wellness and achieve health equity for low-income and minority communities.

COMMUNITY ENGAGEMENT IN IOWA

Local Based Plan

We have traveled over 2,000 miles across Iowa and visited dozens of community-based organizations that make a lasting difference to the through their support of providers, caregivers, social services, Disabled and Disability Services (DDS), and Long Term Services and Supports (LTSS). We are touched by the warmth and hospitality we received and we look forward to joining the efforts of these organizations to improve lives in these communities.

Aetna health plans serve 3 million Medicaid members with information and resources to help them make better decisions about their health care.

In early April, we met with the Executive Director of the Iowa Community Action Association (ICAA). ICAA represents 19 community action agencies statewide and serves over 337,000 Iowans. The programs include low-income home energy assistance; weatherization; community service block grants; Head Start; the Women, Infants, and Children program; hawk-i outreach; Temporary Assistance to Needy Families (TANF); and Accountable Care outreach. We learned about the unique challenges of the counties along the southern border—rural areas with a hard-to-reach population and few churches. We discussed opportunities for Aetna Better Health to help educate Agency staff. ICAA extended an offer to provide office space for our staff.

Table 8-1 shows several of the organizations we have identified by region. Iowa's community-based organizations are working to address clearly identified concerns within the community: Mental health and substance use, transportation and meal services, homelessness, employment support for adults with disabilities, support for caregivers and families, volunteer recruitment and deployment, availability of vaccines, and educational and summer programs for children. The valuable insight of these organizations plays a substantial role as we plan our approach.

***Table 8-1: Local community engagement*-CONFIDENTIAL**

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

	- CONFIDENTIAL	

Attachment 5 – Section 8.1, Question 1 [8.1.1, 8.1.1.1, 8.1.1.2, 8.1.1.3]

Describe in detail your marketing and outreach plans.

Connecting with members through a marketing and outreach plan

Our goals are to improve the quality of health and wellness of our members, grow and retain our membership, and increase the overall awareness of and preference for Aetna Better Health among potential members, current members, providers, and community-based organizations. We plan to accomplish these goals by:

- Educating members and potential members on a variety of important health topics, including well-child visits and vaccinations, prenatal care, asthma, and diabetes management
- Increasing brand awareness to target audiences through participation in outreach activities, advertising, and our website

MARKETING AND OUTREACH – A FOCUS ON OUTCOMES AND RESULTS

Our multimedia approach to member, provider, and community communications program reflects our commitment to meet our members, providers, and stakeholders where they are.

Because each member has unique communication preferences, we will use a variety of marketing and outreach channels and develop creative, personalized, and innovative means to connect with our members. Table 8-2 outlines our marketing and outreach techniques and applications.

Table 8-2: [redacted] CONFIDENTIAL

[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

[redacted]

MARKETING AND OUTREACH ACTIVITIES TO REACH EVERY IOWAN-CONFIDENTIAL

[redacted]

[redacted]

[redacted]

(CONFIDENTIAL cont'd.)

- **Health and community centers** – The Outreach team will identify several high-traffic community health centers, such as the Association of Community Action Agencies, from which we can share information with individuals who are interested in improving their health.
- **Events** – The Outreach team will aim to participate in as many health fairs, community events, workshops, seminars, and grand openings as possible during our first year. Outreach representatives will talk with community members and offer branded health information and promotional items. For example, our Coventry health plan recently attended the Iowa State Fair (Figure 8-2).
- **Churches and religious groups** – We will work in conjunction with all faith groups to promote health education classes, Stakeholder Advisory Boards, events, and sponsorship or participation in health fairs and other community events.
- **Community outreach** – Our Outreach team will work with various community organizations and interact directly with members to provide health educational and instructional materials. We consider Care Management to be part of our expanded team, and we will use Integrated Care Management (ICM) to help build a network of programs that connects members to resources that fit specific member needs.

IN IOWA: A FRESH PRODUCE STAND AT RIVER PLAZA

One example of our community support is through our work with the Food Bank of Iowa in distributing fresh produce and other healthy foods to Iowa households (Figure 8-3). With the help of community allies, our health plan volunteers, and a $12,000 grant from the Aetna Foundation, the Food Bank distributed 42,819 pounds of fresh produce over a 10-week period. Individuals received an average of 23 pounds of food per person.

It was a true community endeavor, with additional produce items supplemented through in-kind donations from local produce vendors, the Fresh Produce Program at the Newton Correctional Facility, and Gardening for Good in Madrid. The program also distributed toothbrushes and an array of nutritious foods including yogurt, bread, cranberry juice, and almond milk.

Figure 8-3: Volunteers from our Coventry health plan supporting the Food Bank of Iowa.

OUTREACH MONITORING AND PLANNING

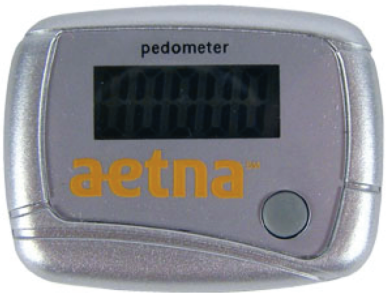
To track our outreach activities, Outreach representatives will complete a visitation form that includes contact information, demographics, and other event details, including an evaluation of the event for future planning.

ALLOWABLE MARKETING ACTIVITIES

With the Agency's approval, our plan and our subcontractors will be permitted to:

- Use mail and mass media advertising, such as radio, television, and billboards.
- Participate in community-oriented marketing events, such as community health fairs.
- Distribute tokens or gifts of nominal value at such events to potential members so long as we are in compliance with all law and policy guidance regarding inducements in the Medicaid program, including marketing provisions provided for in Title 42 CFR §438.104. Figure 8-4 is an example of our giveaways, which primarily promote healthy behaviors.
- Use radio, digital media, public transit, and local newspapers and periodicals to reach and educate potential members on our benefits for health and wellness needs. Photography used in marketing material will depict the various ethnicities and other diversities of our membership.

Figure 8-4: Giveaways typically include health-oriented items such as pedometers



PROHIBITED MARKETING ACTIVITIES

In carrying out marketing activities for the Initiative, we are prohibited from and will avoid:

- Seeking to influence enrollment in conjunction with the sale or offering of any private insurance
- Directly or indirectly engaging in door-to-door, telephone, or other cold-call marketing activities as defined by 42 CFR §438.104, which includes any unsolicited personal contact by Aetna Better Health with a potential Medicaid member
- Enticing a potential member to join a health plan by offering any other type of insurance as a bonus for enrollment
- Engaging in any marketing activities that mislead, confuse, or defraud members or the Agency, or making statements considered inaccurate, false, or misleading

Our Compliance Officer will responsible for marketing oversight. The Compliance Officer will disseminate Agency guidelines and regulations to the individuals who are responsible for marketing tasks. The health plan and shared services Marketing Department will receive the guidelines from Compliance and then develop marketing materials, including collateral and advertising such as print, radio, digital media, transit, and out-of-home advertisements. We will obtain prior Agency approval (at least 30 calendar days or within the timeframe requested) for any marketing materials before we use them. We will consider projected enrollment level to provide adequate coverage for marketing and outreach services of the entire service area.

EQUITABLE MARKETING APPROACH

We will implement policies and programs to promote equitable marketing throughout the state in compliance with Agency and federal law and contractual requirements related to marketing and outreach, including those outlined in Sections 8 of this RFP, and 42 CFR §438.104. We practice equitable marketing in the way we will target, approach, and interact with potential members and the larger community: We plan, design, develop, and present all events and materials in a way that respects and celebrates local traditions and cultures. Equitable marketing identifies and uses the knowledge of community assets to develop offerings for health and quality-of-life improvements.

8.2 Member communications

Attachment 5 – Section 8.2, Question 1 [SOW 8.2.1, 8.2.2, 8.2.4]

Describe your overall strategy for communicating with members.

A strategy focused on multiple communication methods

We will use written, verbal, and in-person communications with our members to:

- Welcome and educate members on program information
- Inform members of program changes and improvements
- Educate members on their rights and responsibilities
- Remind members of upcoming screenings and immunizations
- Promote the importance of preventive health care
- Engage members to make more confident health care decisions

Communication with each member begins on the first day of enrollment. Table 8-3 provides a high-level overview of our initial and ongoing communication.

Table 8-3: Initial and ongoing communications

Timeframe	Channel	Member benefit	Frequency
Days 0-5	Member ID card	Important plan contact information	Initial and upon request

Timeframe	Channel	Member benefit	Frequency
Days 0-5	Welcome packet	Important information on benefits, providers, and how to contact us	Initial and upon request
Days 0-10	Telephone welcome	Warm member reception, CEO message to welcome member	For new members – within timeframe and as early as 10 days post-enrollment
Days 0-90	Health Screening Assessment to identify special health care or care coordination services	Member is identified as a candidate for Care Management or Chronic Condition Management programs	Within 90 days and annually
Days 0-10	Welcome and access to member portal and mobile application	Member education and preventive care	Members can self-enroll as soon as they receive their ID card
Ongoing engagement	Health education materials, member newsletters, outreach calls, immunization reminders, texting, mobile applications	Member engagement for health outcomes, prenatal, and preventive measures, general health notifications	Ongoing for existing members

Our written communication strategy

Because our members' needs and cultural backgrounds are diverse, we tailor our words, the tone of our messages, and any graphic representations to meet their needs, preferences, and expectations. The efforts of Aetna Inc. to improve the simplicity and clarity of communication have been recognized by the Center for Plain Language. Aetna Inc. has received the top honor of the Plain Language Award for the past five years.

Aetna Better Health will create all member presentations and materials using "plain speak." In general, plain speak means we use direct language and a tone that is clear, genuine, optimistic, and purposeful. Plain speak concepts also apply to our design: We make certain all materials are legible and approachable, and we use standardized layouts that apply effective white space and an overall uncluttered design. Specifically, plain means we:

- Write materials at or below a sixth-grade reading level according to the Flesch Reading Ease scale.
- Use active voice, clear word choices, expression, and complete thoughts in our written communications. We avoid jargon and technical language.
- Write in clear, short sentences, helping us simplify the complexities of the health care system, including our members' benefits and services.
- Use clear, easy-to-understand language, helping us clarify questions we receive from our members and potential members.
- Use legible typography in at least 10-point font size and simple layouts.
- Post educational and instructional materials on our website compliant with the Americans with Disabilities Act (ADA) and Section 508 of the Rehabilitation Act of 1973, as amended 29 USC §794(d).

We will translate our written English materials into Spanish and other commonly used non-English languages identified, according to Contract standards. We will make member materials, such as enrollment notices and educational and instructional materials, available in a format our members can understand. The Aetna Medicaid Marketing Department develops the marketing and member materials.

We will adopt the enhanced national standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care developed and promoted by the United States Department of Health and Human Services Office of Minority Health. We strive to meet all 15 standards and through our

Cultural Competency Plan that addresses each of the 14 standards that support the "Principal Standard." We also have our own standards for developing materials—standards consistent with and support the CLAS standards.

WELCOMING NEW MEMBERS

Within five business days of receipt of member enrollment information, we will mail a welcome packet with enrollment materials to each member. The enrollment materials will include:

- A member ID card.
- A welcome letter with our contact information, including address, toll-free telephone number, and website address.
- A member handbook in English and Spanish.
- Information on how to find a network provider near the member's residence, online through our website (www.aetnabetterhealth.com/iowa), or by calling Member Services through our toll-free telephone number. The provider network information provided must include all information detailed in 42 CFR §438.10(e). We will offer online provider directories and make print versions available upon request.

Our verbal communication strategy

When a current or potential member reaches out to our member helpline, a Member Services Representative will answer the question clearly and to the member's satisfaction. The Member Services Representative will end each call with a closing statement. Depending on the call, the Member Services Representative will ask the member:

1. Did I answer all your questions?
2. Is there anything else I can assist you with?

We will provide interpretation services and language translation services at no cost to the member. Our interpretation subcontractor offers interpretation services in 200 languages, including Spanish, Serbo-Croatian, Vietnamese, Lao, German, and more.

Face-to-face communication

Our Case Managers play a leading role in our face-to-face communications with members. They meet in person with members and their families to perform assessments, create and support the member's Care Plan, and lead Case Management activities. Case Managers are a vital part of our strategy, helping our members build trust in Aetna Better Health and helping educate members and their communities with a personal, targeted approach. Case Managers are key to bridging gaps, addressing cultural and language barriers, and empowering members and their families toward self-direction and improved outcomes.

Our community outreach efforts will aim to help improve health outcomes by educating the community on important health topics and increase brand awareness to grow and retain membership. We will employ several outreach tactics to achieve these goals. Our Community Outreach Department plans to participate in several events in our first year, including health fairs, community events, workshops, seminars, and grand openings. They will also engage faith groups to contact the hard to reach members.

Regulatory standards

We will prominently display our health plan name, logo, physical location, website address, and toll-free number on all marketing materials. We will submit all member education materials and other marketing and member materials to the Agency for review and approval before distributing within our

membership. Upon request from the Agency, we will distribute information prepared by the Agency or the federal government to members and providers as appropriate.

Attachment 5 – Section 8.2, Question 2 [SOW 8.2.2, 8.2.7]

Describe your plans to provide oral interpretation services and translated written information and how you intend to notify members of the availability of these services and how to obtain these services.

Plan for verbal interpretation

Our members come from various backgrounds and ethnicities. This requires us to be prepared to meet their unique needs. For members who have limited English proficiency and would prefer to speak another language, we offer:

- A bilingual helpline staff fluent in English and Spanish
- Interpretive services through Voiance, which provides language interpretive services for over 200 languages

We offer sign language interpreters and can provide their services at provider appointments. We document all interpreter offers and responses, including sign language, in the business application system.

We recognize and are sensitive to the needs of our racially and ethnically diverse members and will adopt enhanced national standards for developing member materials. CLAS standards are developed by the United States Health and Human Services and Office of Minority Health. It is our goal and intent to meet all the CLAS standards. Our Cultural Competency Plan addresses these standards, and we incorporate them into our member communications to help eliminate health inequities. Our goal is consistent with national standards to help advance better health and health care in the United States.

Plan for written translation

Aetna Better Health provides our written materials in English and Spanish, and we will publish written material in any additional languages requested by the Agency at no cost. Our ISO 9001-certified translation vendor translates the written materials into Spanish. Furthermore, our highly trained staff and Stakeholder Advisory Board will review the content to confirm the translated material preserves the nuances, meanings, and subtitles of the original text. For members who speak languages other than

Marco (not his real name), an 18-year-old member in another Aetna Medicaid health plan, was frequently hospitalized due to paranoid schizophrenia. The severity of his condition had deeply affected his day-to-day living, so his mother left her job to take care of him. Due to cultural and language barriers, Marco's family was reluctant to receive care and take recommendations from the care team.

Marco's Care Manager, Amy, brought in an interpreter to help her talk with Marco's mother. Through the interpreter, Amy built a relationship with Marco's mother and earned her trust. Amy offered education and resources for Marco's condition and options for support. After some time, Amy recommended a Care Plan for Marco. Marco's mother agreed and accepted the plan.

Working with the hospital counselor, Amy found supportive housing that could accept Marco. Amy continues to work with Marco's family to promote improvement in his condition and make certain his family feels connected, united, and active in Marco's care.

English and Spanish, we can provide written translation.

Informing members of interpretation and translation service availability

We want our communications to be easily accessible and useful to all of our members. Upon receiving enrollment information from the Agency, we will update member demographic information on language preference. We will also subscribe to additional services that will allow us to maintain updated member demographics.

We will inform members of the availability of interpretation and translation services through new member welcome calls and member materials, ongoing member outreach, community outreach activities, and targeted outreach. Our welcome letter will provide information on important telephone numbers to reach our staff, and the member ID card also lists telephone numbers and a Telecommunication Device for the Deaf (TDD) number.

Our members can call our Member Services staff and obtain interpretation and translation services. Our Member Handbook includes information on interpreter services and contact numbers in the event a member is unable to use the Member Handbook or requires written translation in a language other than English and Spanish. Our written materials will include taglines in prevalent languages to guide members on how to further access these materials. We also provide translation on other materials such as Utilization Management letters and Care Plans.

Our member hotline call tree offers a Spanish language option that will route the caller directly to a Spanish-speaking interpreter. Additionally, members can elect to use immediate interpretation services.

Attachment 5 – Section 8.2, Question 3 [SOW 8.2.3, 8.2.4]

Describe your plans to provide all written materials in alternative formats and how you will identify members needing alternative formats.

Materials in alternative formats

We will make all written materials available in alternative formats such as Braille, large print, and audio and verbal explanations upon request, including how to access these formats. Our member materials will indicate that interpretation and translated materials in other languages are available and will explain how to access these materials.

These alternative formats can support members who are visually or hearing impaired, members with limited reading proficiency, or members with other special needs. We provide educational and instructional materials on our website and comply with the ADA and Section 508 of the Rehabilitation Act of 1973, as amended 29 USC §794(d).

Lily, an LTSS member in another health plan, contacted the Member Services Department about the Member Handbook. Lily wanted a different format for the handbook because she and her boyfriend are visually impaired. Lily first requested a DVD, but after clarifying the member's needs, the department determined that an audio CD might be a better option to meet Lily's needs.

Lily enthusiastically agreed. The health plan developed the audio CD and a large-print handbook. An LTSS Care Manager delivered the handbooks personally to assist with any questions about the CD or book. When we checked in with Lily again, she confirmed she was extremely happy that she was able to listen to her Member Handbook.

Our TTY/TTD relay services are available always at no cost to assist hearing impaired members. We provide sign language interpreters upon request with advance notice. Upon request, we can adapt our

member materials to include large print, Braille, and audio versions. For members who are visually impaired, we will make staff available to read and explain any materials.

We will train our Member Services Representatives to address barriers to hearing and visually impaired members. One of our training tools helps staff better understand the challenges of having a hearing deficit for even a very simple conversation. The training tool provides soundtracks that help staff learn firsthand how hearing loss changes perception. This type of training tool is critical when working with hearing-impaired members and demonstrates the effectiveness of the quality of service we provide to our members who are hard of hearing.

We will train our Member Services staff to review subject matter with members who have low levels of literacy and make certain all members can read the member handbook or any printed member material. Our staff will review printed materials with our members, including benefits and the member's rights and responsibilities. We will arrange in-person meetings with members and the Member Advocate to help confirm that members understand our materials. We may also suggest a conveniently located venue for members to receive personal assistance.

Identifying members in need of alternative formats

To personalize and customize the communication, we will maintain a database of current member with demographic information and other health-related data collected by the Agency. We develop reports on race, ethnicity, language, and health risk factors to identify member needs. When we perform a member's initial health risk assessment, we will identify members who have special needs. Our system has special codes to help us identify members who are part of the Aged, Blind, and Disabled population.

Attachment 5 – Section 8.2, Question 4 [SOW 8.2.5]

Describe your policies and procedures for ensuring materials are accurate in content and translation.

Ensuring accurate content and translation for member materials

Our focus and commitment to providing marketing and member materials that meet language and reading-level requirements is a company-wide endeavor. With the support of our Chief Operating Officer, Member Services, Member Advocates, Legal, and Compliance, the Communications Department produces and oversees the development of member materials to make certain that we meet federal and State guidelines, including language and reading level requirements.

Before we submit member materials to the Agency for ensuring accuracy in our original and translated member materials, all draft materials must complete multiple reviews:

1. **Legal and compliance review** – Led by our Legal and Compliance departments, this review checks for compliances with internal requirements plus federal, State, and Contract requirements.
2. **Stakeholder Advisory Board review** – The board will review draft member materials and provide feedback regarding readability, comprehension, and cultural competency. The board members will represent diverse backgrounds and program perspectives, including those of members, family members or other caregivers, providers, community organizations, member advocates, and our rotating staff. Their review and feedback will allow our staff to gauge education and health literacy levels and identify ways in which specific cultural aspects can help us communicate more effectively.

3. **LTSS Member Advisory Board review** – In response to the specific needs of our LTSS members, an LTSS Member Advisory Board will meet once every quarter and at various locations in the community where members gather to receive services or participate in community activities. Advisory Board members review samples of member materials and provide feedback on wording, accuracy, clarity, visual presentation, and their overall helpfulness as educational pieces or resources. Members will be asked to provide comments on the program and make suggestions for improvement on the delivery of those services.

Our Member Services staff is available to read and explain any materials to a member who has difficulty understanding them.

As per section 42 CFR 438.104, we will seek approval from the Agency for all marketing materials distributed to the community, potential members, and current members. This will be done at least 30 days in advance or within the timeframe requested by the Agency. We will follow all requirements outlined in section 42 CFR 438.10. For example, the materials developed will be easily understood by the members or will be made available in the prevalent non-English language in the service area.

Attachment 5 – Section 8.2, Question 5 [SOW 8.2.6, 8.2.6.1 – 8.2.6.23.2]

Provide sample member enrollment materials as described in Section 8.2.6.

Within five business days of receiving eligibility files from the Agency, we will distribute enrollment materials to each member. All information in the enrollment materials will meet the requirements in Section 8.2 and will be submitted for Agency review and approval prior to distribution following the process established in Section 8.2.4. The enrollment materials will include all contents listed in subsection 8.2.6.1 through 8.2.6.23.3.

Please see Appendix H for sample enrollment materials.

Attachment 5 – Section 8.2, Question 6 [SOW 8.2.8]

Describe your processes for identifying significant changes as described in Section 8.2.8 and notifying members of such changes.

Our process to identify significant changes

Our processes for identifying significant changes will follow specific contract requirements set forth by the Agency. Typically, we define a change as when the Agency modifies requirements or there is a change in the provider network. Figure 8-6 provides an overview of our process flow for identifying changes and notifying our members.

The Aetna Better Health Contract Administrator will be responsible for identifying any changes in the Contract or program requirements. Our Contract Administrator is typically our CEO, COO, or Compliance Officer. The Contract Administrator will then initially assess the change and notify impacted departments. We then draft a member notification for approval by the Agency and notify staff, such as Member Service Representatives, Case Managers, or others who interact directly with members.

Notifying members about change

We will notify members in writing when there is a significant change, specifically when the change may affect member accessibility to services and benefits. These changes may include:

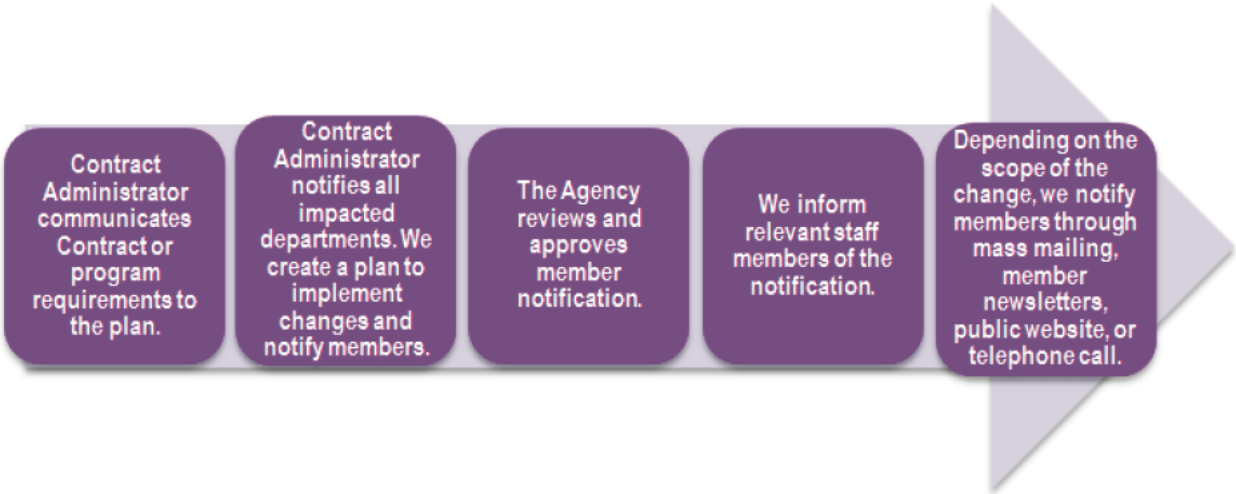
1. Restrictions on the member's freedom of choice among network providers
2. Member rights and protections
3. Grievance and fair hearing procedures
4. Amount, duration, and scope of available benefits
5. Procedures to obtain benefits, including authorization
6. Processes to obtain benefits from out-of-network providers
7. Referral policies for specialty care and for other benefits not furnished by the member's PCP
8. Cost sharing

Depending on the type of change, we may notify members through mass mailings, member newsletters, the public website, or by telephone. We will send our draft notification to the Agency for review and approval before distributing it to our membership. Provider Service Representatives will also communicate changes to impacted providers. Figure 8-4 displays our streamlined process to identify change and notify members.

We received a call from Susan, a 36-year-old Maryland member who is blind and has diabetes. Susan's deliveries of test strips had stopped and she did not know what to do. Our Maryland Member Services Department found an issue with the test strip provider and called them directly. The provider agreed to fix the issue and overnight the test strips to the member.

Susan called Member Services again after she received the test strips to thank the team. She said knowing they were there to assist her and take care of her health needs gave peace of mind to both her and her family.

Figure 8-4: Our streamlined process to identify change and notify members



8.3 Member Services Helpline

Attachment 5 – Section 8.3, Question 1 [SOW 8.3]

Describe your plans for the member services helpline, including the days and hours of operation.

Our Member Services Department will support members with assistance, education, and outreach through a dedicated Member Services helpline. The helpline will follow our first call resolution policy, meaning we will not hang up until the member is satisfied with our responses.

We use Avaya telephone system to support and manage calls. To staff the helpline, we will hire local Member Services staff with knowledge and understanding of the local landscape. They will be skilled and highly trained with an understanding of our member needs and priorities.

Hours of operation

Standard hours of operation for the Member Services helpline are Monday through Friday, 7:30 a.m. to 6:00 p.m. Central. After regular office hours and on holidays and weekends, we will offer an after-hours helpline on the same toll-free number.

Members who call the helpline will have the option to talk directly with a Nurse or other clinical specialist. Our Member Service Representatives address member needs immediately. Our Member Services Representatives do not have voice mailboxes, which eliminates the possibility that a member might leave an urgent message of which we are not immediately aware.

Aetna Better Health will follow the State holiday schedule:

- New Year's Day
- Martin Luther King Jr.'s Birthday
- Memorial Day
- Independence Day
- Labor Day
- Veterans Day
- Thanksgiving
- Day after Thanksgiving
- Christmas Day

We document all calls the same system to allow for continuity. After-hours calls to the Member Services helpline will automatically route to our helpline in Phoenix, Arizona. This helpline offers expert, cross-trained Member Services staff who will address the needs of our members. The system uses prompts to route each call to a Member Services Representative with an appropriate level of assigned training and skill. For example, the most common Medicaid skill configurations focus on general or specific foreign language, prior authorization, pharmacy, or provider. There may also be a specific skill for working with members from a targeted population such as LTSS, dual eligible, or CHIP.

Aetna Better Health will provide 24/7 Member Services support.

Attachment 5 – Section 8.3, Question 2 [SOW 8.3.1, 8.3.6]

Describe the process you will utilize to answer, route, track and report calls and inquiries. Indicate if an Interactive Voice Response (IVR) system is proposed.

Answering calls or inquiries

Members will have one statewide, toll-free number to call with questions or concerns. When members contact Aetna Better Health, they will first hear:

- An automated greeting that welcomes the member to the Member Services access line
- Instructions (in English and Spanish) to hang up and dial 911 for matters involving a life-threatening emergency

- An option to be transferred to a bilingual representative
- A message that notifies the member that the call may be monitored for quality control purposes

Our Member Services Representatives will be located in the Iowa office during regular business hours and use our business application system to document each member call, including recommendations and actions.

When a member calls our helpline, the member will hear options to connect to different departments. Member Services Representatives can also directly transfer member calls to other departments. Our standard protocol is to use a warm transfer to connect and formally introduce both parties and to inform the connected department staff of all information shared up to the point of transfer. Members can speak with after-hours Member Services staff or connect to our 24-Hour Nurse Call Line if their assigned Case Manager is not immediately available.

Our call management system includes monitoring and reporting capabilities to help us exceed all performance standards, including quality of calls and member satisfaction. Members then have the opportunity to select additional options to access services based upon their specific needs; for example, Member Services, assistance with eligibility, and assistance with transportation services. If the member first connects to a Member Services Representative, the Member Services Representative can transfer members directly to the appropriate department. Before transferring a member to another individual, the Member Services Representative will request a callback number so we reconnect to the member if the connection is lost.

If a member has a request for medical advice, the Member Services Representative will transfer the call to an available clinician. Member Services Representatives will also tell members that they can facilitate a call with their PCP or the Nurse Call line for additional information. If the situation is an emergency, the representative will initiate our crisis workflow.

PROCESS TO HANDLE FRAUD AND ABUSE CALLS

We will request members and providers to report suspected fraud and abuse to the health plan. We will offer members an option to report fraud and abuse via our web portal, and members may also report packet and handbook.

REFERRALS TO THE BEHAVIORAL HEALTH CRISIS LINE

Behavioral Health crisis calls will be handled during regular business hours. Once a Member Services Representative determines that a call is a behavioral health crisis call, the Member Services Representative will use instant messaging to contact a member of the behavioral health crisis team. By keeping the member on the line while using instant messaging to communicate to the responder list, the Member Services Representative saves valuable time in getting help to the member. Behavioral Health Instant Messenger responders include at least the following staff, by title:

- BH Case Manager (1st responder); UM or CM, BH or Nurse
- BH Case Manager (2nd responder); UM or CM, BH or Nurse
- CMA who can assist with urgent appointment
- Supervisor of Case Management or UM
- Manager of Case Management or UM
- Supervisor of Member Services for escalation

The Member Services Representative will warm transfer the member to a clinician staying on the line with the member to confirm the transfer is complete. Upon completion of the call, the Member Services

Representative will document the call into the business application. Our staff will manage all crisis calls during normal business hours. After regular business hours, our specialized after-hours team of behavioral health professionals will respond to behavioral health calls, including crisis calls. The information will be forwarded to a local care manager for follow up with the member. Our Member Services Representative's also receive specialized training on mental health first aid and suicide signs, which are:

- Contemplation—Signs that a member is thinking about suicide (suicidal ideation)
- Intent—Signs that the member has the intent to hurt or kill himself or herself
- Means—The member has the means to harm himself or herself
- Plan—The member has a plan to hurt or kill himself or herself

Tracking calls and inquiries

Our Member Services Representatives will use the call tracking system to document the source of the call, the nature of the inquiry, and the required resolution. We will implement advanced workflow management tools to support the manual and automatic routing of members to the appropriate person or group. During and after a call, we will assign follow-up tasks and reminders as needed to make certain we have fully resolved each member's inquiry.

REPORTING CALLS AND INQUIRIES

We will maintain a service level of 80% for incoming calls as per specified in Section 8.3.3 of the Contract. We will track the Member Services helpline system metrics as required by the State. The call system will display statistics in 30-minute increments throughout the day for each telephone queue, enabling the Member Services Supervisor to monitor the Department's performance levels. Using real-time data with a one second refresh rate, the display will identify which Member Services Representatives are available to accept calls, which are on a call, and which are in post-call wrap up. In the event in the event incoming call volumes reach a pre-determined alert level, an additional system feature displays a light to signal Member Services Representatives to return to Available status. We can also dynamically redistribute Member Services Department calls to other offices in case of service interruption, which affords members a virtually failsafe means to reach our staff.

We will summarize the results in a monthly report that trends and forecast call volume to confirm availability of proper telephone coverage for anticipated call volumes for all lines. The Director of Member Services is accountable for this function. Our Member Services Supervisor works with the Workforce Management team and uses a daily dashboard to review productivity in real time and can identify peak times to schedule staff breaks and time off without affecting service levels. If the Workforce Management team identifies a fluctuation in volume, the number of Member Services Representatives on the queue will quickly adjust to balance and align service metrics. The Workforce Management team can reassign staff from other projects to return to our helpline or enlist other cross-trained staff. We can use this data to identify any needs for additional staff training based on lags in answer time or inconsistencies. These tools also aid in efforts to forecast future staffing needs. Figure 8-5 displays a sample Key Indicator Report.

Figure 8-5: Key Indicator Reports help us stay compliant and exceed on our performance metrics

MEDICAID KIR	Standard	06-Mar	13-Mar	20-Mar	27-Mar	TOTAL
Total Calls Received		3862	4691	4579	4707	17839
Total Calls Answered		3784	4664	4558	4661	17667
Total Calls Abandoned		78	27	21	46	172
Abandonment Rate	**5%**	2.0%	0.6%	0.5%	1.0%	**0.96%**
Average Answer Time	**:30**	0:16	0:04	0:06	0:08	0:08
Average Talk Time	**4:00**	3:42	3:39	3:48	3:49	3:44
Service Level Percentage	**85%**	86.18%	95.1%	92.9%	89.3%	**90.85%**
Total FTE (Budgeted)	**17**	17.00	17.00	16.00	16.00	**17**
Total Hours (7.5 hrs)	**37.5**	637.5	637.5	600	600	**618.8**
Hour (time off phones)	hrs x fte	0.0	0.0	0.0	0.0	**0.0**
FTE (time on phones)		17.0	17.0	16.0	16.0	**16.5**

IVR system

Aetna Better Health will use the Avaya telephone system, which is a Private Branch Exchange (PBX) with call trees. We maintain a simple call tree offering members several options to get to the correct entity to address their concerns. Our callers will be connected to a live person within if the caller chooses that option. Our standard helpline platform is an Avaya PBX configured in a clustered environment and a Cisco Intelligent Contact Manager that provides virtualization across telephone systems. This configuration can support up to 370,000 calls in an hour. This cluster is one of nine that provides telephony functionality to all of our helplines. Calls can be shared between clusters through distributed IP support and Cisco Intelligent Contact Manager, which will allow for real-time fail-over with multiple levels of redundancy to maintain uptime and dynamic distribution of calls if needed. In fact, it would take four separate points of failure to bring a cluster down. Even then, we can reroute calls to another cluster. The clusters and associated adjuncts are monitored 24/7 by our Network Operations Center (NOC) and managed by an on-call Telecommunications and Engineering staff. This provides members with a virtually fail-safe means to reach us whenever necessary.

We will route all incoming member calls to the staff member with the training, skills, and experience to resolve the issue. Should the staff member require additional assistance, the Avaya telephone system will support the seamless transfer of any incoming call elsewhere within the team or to a different area of Aetna Better Health.

Attachment 5 – Section 8.3, Question 3 [SOW 8.3.1]

Describe your plans to provide services for the hearing impaired and non-English speaking population.

Serving members who are hearing impaired

Our Member Services helpline will be avaliable to all callers and we always offer TTD relay services at no cost to the member. TTD services are commonly used to assist hearing impaired members. As described above, our staff receives specialized training to interact with members who have hearing impairment. We will maintain and operate TDD services for hearing impaired members. We will also post and use the Iowa Relay service to enable continuity of services for members.

Calls from non-English speaking population

Our system allows users to document language preferences in the member's record or to update those that we receive directly from the State.

For members who speak Spanish, our call routing system will provide an option to connect directly to one of our Spanish-speaking Member Services Representatives. In the event a Spanish-speaking Member Services Representative is not available, we will then connect with Voiance for an interpreter. Voiance is a language services company that offers immediate interpretation for Spanish and hundreds of other languages at no charge to the member.

If a member needs an interpreter for a language other than Spanish, the member may bypass the telephone tree and enter the Member Services call queue.

When Member Services Representatives require interpretation services, they call the Voiance toll-free number for the service, enter our access code, and tell the automated attendant which language the member needs. After the service establishes a connection with the interpreter, the Member Services Representative follows our protocol to interact with the interpreter and the member and document the call. Figure 8-8 shows a 2014 sample report on calls received by Voiance. For year 2014, 1.5% of the total calls received were referred for interpretive services. Please see Figure 8-6 for the 2014 report for interpretive services tracks member-requested languages.

In 2014, members of an Aetna health plan used interpretive services for 50 different languages.

Figure 8-6: 2014 report for interpretive services tracks member-requested languages

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2014	248	226	375	354	281	252	238	254	246	235	200	227
Total MS Calls 2014	17858	16568	19132	24174	18024	18968	19729	18380	17317	17845	15462	18597
	1st Quarter			**2nd Quarter**			**3rd Quarter**			**4th Quarter**		
2014												
Albanian		0.4%										
Amharic	0.8%	1.3%	0.8%	1.1%	1.8%	2.4%	0.4%	0.4%	0.8%	1.3%		0.9%
Arabic	0.8%	0.4%		1.1%	1.1%	0.4%	0.8%	0.4%	0.4%	0.4%	0.5%	
Assyrian												
Bengali											0.5%	0.4%
Brazil		0.4%										
Burmese			0.3%	0.3%	0.4%			0.4%	0.4%	0.4%		0.4%
Cantonese				0.3%	0.7%	1.2%			0.8%			0.9%
Cambodian												
Chin												
Ethiopian		1.3%							0.4%			
Farsi			0.3%					0.8%			0.5%	
French	0.4%	1.3%	1.3%	1.4%	1.1%	2.0%	2.5%	2.4%		3.4%	3.0%	0.4%
Georgian												
Gujarati						0.4%					0.5%	
Haitian Creole	0.4%			0.3%		0.4%	0.8%			0.4%	1.5%	
Hindi		0.4%		0.6%			0.4%	0.4%				
Indonesian												
Japanese												
Karenni					0.4%							
Korean	0.8%	2.9%	0.3%	1.4%	0.7%	2.4%	1.7%	1.2%	1.2%		3.0%	1.8%
Kurdish												
Laotian												
Mandarin	2.0%	0.8%	0.8%	2.5%	2.8%	1.9%	3.8%	3.2%	3.3%	2.6%	1.5%	1.8%
Mandingo							0.4%					
Malayalam												
Nepali			0.5%	0.3%				0.4%			0.5%	
Oromo												
Pashto												
Persian					0.4%							
Polish	0.4%			0.3%								0.4%
Portuguese												
Punjabi												
Romanian			0.3%									
Russian				0.3%		1.2%		0.4%	0.4%			0.4%
Somali												
Sorani												
Spanish	93.9%	89.0%	94.9%	89.3%	89.0%	86.9%	85.3%	85.4%	89.8%	88.1%	87.5%	92.1%
Swahili									0.4%			
Tagalog												
Tamil												
Thia			0.3%						0.4%	0.4%		
Tibetan												
Tigringna				0.3%				0.8%				
Turkish					0.4%		0.8%	0.4%				
Twi					0.4%							
Urdu	0.4%	0.8%			0.4%			0.4%		0.9%	0.5%	
Uzbek												
Vietnamese	0.4%	0.8%	0.3%	0.6%	0.4%	0.8%	2.9%	3.2%	1.6%	2.1%	0.5%	0.4%
Yoruba												
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Attachment 5 – Section 8.3, Question 4 [SOW 8.3.2]

Describe your training program curriculum and training process for call center staff.

Training program curriculum

Our Learning and Performance Department will build a thorough training program, equip new hires, and then administer initial and ongoing training for our staff.

In addition to standard Aetna Better Health onboarding curriculum, our Member Services staff will receiving training on Iowa-specific concerns, such as how to access health care services, identification or explanation of covered services, procedures for submitting a grievance or appeal, how to report fraud or abuse, how to locate a provider, balance billing issues, cost-sharing and patient liability inquiries, and incentive programs.

NEW STAFF TRAINING

We will provide initial and ongoing training for staff and subcontractors to become knowledgeable and skilled in an integrated health care service delivery system. Onboarding for new staff (including staff, contractors, and interns) includes:

- Welcome to Aetna Medicaid Orientation and Iowa Program overview
- Cultural Competency and soft skills for hearing impairment and generational differences
- Standard courses such as HIPAA Privacy Overview, Fraud/Waste/Abuse, diversity training, Code of Conduct, and Information Security
- Job-specific online courses including Provider Preventable Conditions, Service Excellence, Patient Quality of Care (PQoC)
- On-the-job training including System Training, Documentation, Grievance and Appeals, Policy and Procedure Overview
- Onboarding attestation

CRISIS TRAINING

Our Member Services Representatives will receive comprehensive training for appropriately handling urgent or emergency calls to behavioral and physical health staff in Utilization Management, Care Management, Long Term Care, Disease Management, or Member Services, including:

- Handling and transferring potential crisis calls
- Emergent life-threatening and non-life threatening calls – clinical
- Urgent and routine calls – clinician role
- Call documentation and follow-up – clinician role
- Contact options for emergency services

ONGOING AND REFRESHER TRAINING

After the initial training, we provide quarterly refresher training for all Member Services Representatives to review standard course content and share updates. We also update Member Services Representatives on critical issues through ad hoc methods such as memos and desktop procedure updates.

Ongoing training includes topics such changes to covered service; new training tools; contract changes; complaints, grievances, and appeals; fraud and abuse; and HIPAA. Member Services Representatives must also complete required annual training on topics such as compliance and cultural competency. We also provide helpline system updates and new features as needed.

We will specifically train our Member Services Representatives to address critical incident issues for our LTSS and behavioral health members. We believe monitoring, tracking, and investigating critical incidents are essential to ensuring the health and welfare of our members. Some examples of critical incidents are seclusion, neglect, deprivation, or restraint of a member.

Our training process

A variety of approaches help Member Services Representatives reinforce their knowledge while improving their overall member engagement technique, including one-one mentoring, meetings, role-play, training manuals, desk-level procedures, and printed materials. Our training program is based on the Member Services Policy and Procedure Manuals. The focus of the Learning and Performance department for the Aetna Better Health contract is to confirm contract compliance related to staff training and education. We will have a comprehensive training program to meet the diverse learning needs of our community. The training program is available in multiple formats such as online courses, instructor led, and virtual or small group activities.

New Member Services Representatives receive four to five weeks of training. The first week covers general onboarding requirements such as HIPAA, compliance, and cultural competency. The second week covers all the policies and desktop procedures for member helpline calls, with curriculum including crisis calls, covered services, documentation of calls and grievances, and the appeals process. After two weeks of classroom training, we pair each Member Services Representative with a peer for job shadowing. The Member Services Representative will start to receive calls as well. In addition, the feedback from our call monitoring program helps all Member Services Representatives with member questions. Occasionally, subject matter experts from various functional areas will provide extensive training and materials to focus on the new benefit structure or contract changes.

Attachment 5 – Section 8.3, Question 5 [SOW 8.3.3,8.3.6]

Describe your helpline monitoring process to ensure helpline performance metrics are achieved.

Our helpline monitoring process

We will record and monitor all calls as part of our Call Monitoring Program. The Member Services Supervisor monitors Member Services Representatives for performance and adherence to processes. The Member Services Supervisor and the Call Quality Assurance monitor real-time calls and recordings to promote quality and apply the results in training updates. When reviewing calls, the Member Services Supervisor and Call Quality Assurance Specialist use pre-determined criteria to be sure each Member Services Representative has:

- Confirmed the caller as the member or authorized party on a member's behalf, following HIPAA validation protocols
- Properly verified demographic information and used scripts appropriately
- Communicated accurate product information, had courteous tone and demeanor
- Answered all member inquiries and documented the conversation accurately

The Member Services Supervisor and Call Quality Assurance Specialist grade all calls on a call excellence rating scale. We recognize and reward high-performing Member Services Representatives for exceeding call quality performance standards. For those Member Services Representatives identified as needing more support, we provide additional training, coaching, and feedback. We will then monitor these Member Services Representatives in real time for 30 days to confirm their performance meets department standards.

COMPLIANCE WITH PERFORMANCE STANDARDS

We will monitor our member services helpline and report its telephone service level performance to the Agency in the timeframes and according to the specifications described in the Reporting Manual. We make certain that our helpline is adequately staffed so we can provide timely, accurate support to our members. This helps us provide high quality service and maintain compliance with our performance standards. To support our members, we maintain a standard of:

- Service level of 80%
- Abandonment rate of less than 5%
- Average speed of answer of 30 seconds

We will maintain a service level of 80% for incoming calls as per specified in Section 8.3.3 of the Contract. We will track the Member Services helpline system metrics as required by the State. The call system will display statistics in 30-minute increments throughout the day for each telephone queue, enabling the Member Services Supervisor to monitor the Department's performance levels. Using real-time data with a one second refresh rate, the display will identify which Member Services Representatives are available to accept calls, which are on a call, and which are in post-call wrap up. In the event in the event incoming call volumes reach a pre-determined alert level, an additional system feature displays a light to signal Member Services Representatives to return to Available status. We can also dynamically redistribute Member Services Department calls to other offices in case of service interruption, which affords members a virtually failsafe means to reach our staff.

We will summarize the results in a monthly report that trends and forecast call volume to confirm availability of proper telephone coverage for anticipated call volumes for all lines. The Director of Member Services is accountable for this function. Our Member Services Supervisor works with the Workforce Management team and uses a daily dashboard to review productivity in real time and can identify peak times to schedule staff breaks and time off without affecting service levels. If the Workforce Management team identifies a fluctuation in volume, the number of Member Services Representatives on the queue will quickly adjust to balance and align service metrics. The Workforce Management team can reassign staff from other projects to return to our helpline or enlist other cross-trained staff. We can use this data to identify any needs for additional staff training based on lags in answer time or inconsistencies. These tools also aid in efforts to forecast future staffing needs.

Attachment 5 – Section 8.3, Question 6 [SOW 8.3.4]

Describe your plans for a backup solution for phone service in the event of a power failure or outage or other interruption in service.

Helpline emergency backup plan: Reliable systems, dependable care

Aetna Better Health will maintain a backup plan and system to make certain the system is in place and functioning in the event of a power failure or outage. The system includes:

- A back-up system capable of operating the telephone system at full capacity with no interruption of data collection
- A notification plan that confirms the Agency is notified when our telephone system is inoperative or a back-up system is being used
- A manual back-up procedure to allow requests to continue processing if the system is down

We have a centralized PBX with survivable servers. The design allows for the growth in one or more locations by adding components. The component pieces or telephones can be added anywhere in the

world where service is available and will register back to the main processor in our data centers. We regularly update our telephone system components to maintain currency and relevant feature access. All upgrades that would result in a disruption to service are scheduled during off hours. For our 24/7 helplines, we mitigate customer impact by shifting calls to alternate locations or providing access to remote telephone systems using advanced telephony solutions.

Our voice infrastructure design and applications allows us to accommodate multiple business continuity plans for call routing. Based on business requirements, we can set up calls to automatically reroute during an outage. Our routing plans allowing designated coordinators to activate remotely or contact remotely located engineers to activate alternate routing plans.

Attachment 5 – Section 8.3, Question 7 [SOW 8.3.5]

Describe if any separate member services lines or staff will be used to address member needs by service type (i.e., physical health, behavioral health and long-term care services).

Our seamless integrated helpline

Pioneer in Fully Integrated Care

Members who call the Member Services helpline will use a single number to reach us, regardless of whether their call is for physical health, behavioral health, or LTSS.

The call begins with the Member Services Representative asking the caller about the nature of the call. If it is a crisis call, the Member Services Representative will immediately acknowledge the caller's situation with calming techniques. We will then either route the call or warm transfer the caller to appropriate staff.

If we identify the call as a physical health need:

1. The Member Services Representative will Instant Message (IM) the crisis call group to locate an available clinician.
2. The Member Services Representative will inform the caller that they can transfer her to a clinician who has been trained to handle situation relevant to their physical need.
3. The Member Services Representative will warm transfer the member by staying on the telephone with the member to confirm the caller is connected to the clinician and not placed on hold.

If we identify the call as a behavioral health need:

If the caller asks about general information such as provider information or community resources, our Member Services Representatives will be able to assist. However, if the member appears to be crisis, our Member Services Representatives are trained to identify member needs.

1. The Member Services Representative will connect to responders who are trained to manage a behavioral health crisis.
2. The Member Services Representative will provide the member's name and telephone number and a brief description of the member's issue to the Behavioral Health Case Manager.
3. When the Member Services Representative completes the transfer of the call to the Behavioral Health Case Manager.
4. The Member Services Representative stays on the telephone with the member to be certain the caller has been connected to a live person and was not placed on hold.

If we identify the call as an LTSS need:

1. If an LTSS member calls Member Services, the Member Services Representative can directly answer questions about accessing health care services, covered services, grievances and appeals, fraud and abuse, finding provider information, health crises, balance billing issues, cost-sharing and patient liability, and incentive programs.
2. For other questions, the Member Services Representative will warm-transfer the caller to the Case Manager.
3. If the Case Manager is not available, the Member Services Representative will use our care management system to assign a task to the Case Manager to return the member's call. The task will come up on the Case Manager's To Do list when the Case Manager comes back online. The Case Manager will return the call within 24 hours.

Attachment 5 – Section 8.3, Question 8 [SOW 8.3.6]

Describe proposed entities to which you will be capable of warm transferring member calls.

Warm transferring member calls

As required by the Agency, we can warm transfer calls both internally and externally. When a member calls into our helpline, the member will follow telephone system prompts to connect with a staff member. When transferring the member between staff, our standard transfer protocol is to use a warm transfer to connect and formally introduce both parties and to inform the connected department staff of all information shared up to the point of transfer. For behavioral health inquiries, the Member Services Representative will warm transfer the member to a behavioral health clinician, staying on the line with the member to confirm the transfer is complete. Upon completion of the call, the Member Services Representative will document the call into our business application.

When assisting members with appointments and other services, our Member Services Representatives will also warm transfer the member. The warm transfer can connect the member to internal and external resources, including member's Case Manager; Utilization Management; Behavioral Health; the Nurse Call Line; the internal compliance hotline; language interpretive services; provider offices; vision, pharmacy, and transportation subcontractors; community resources; and the Agency to report child abuse, dependent adult abuse, fraud, or concerns about care facilities.

8.4 Nurse Call Line

Attachment 5 – Section 8.4, Question 1 [SOW 8.4]

Describe how the Nurse Call Line will be publicized to members.

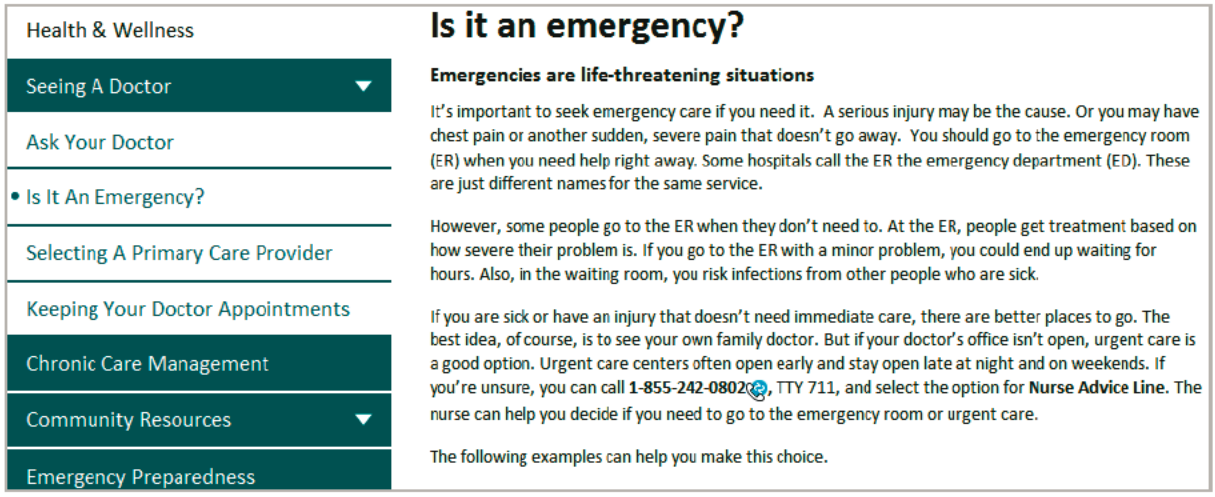
Promoting our Nurse Call Line

We will educate our members about purpose and availability of the Nurse Call Line through:

- **Member handbooks** – The benefits section of the member handbook lists the various services members receive. This list includes availability of 24-hour nurse help line. Additionally, the member handbook also provides valuable information on how and when to access the Nurse Call Line.
- **Member ID cards** – Our member ID cards include the telephone number for the Nurse Call Line.
- **Our public website** – Our website provides general guidance on when to use the Emergency Department and when to call our Nurse Call Line (Figure 8-9).

- **The member web portal** – Members can contact a Nurse Call Line licensed nurse or clinician online. This service provides secure transmission of electronic communication with safeguards and a 24-hour turnaround. Our member web portal is also compliant with Section 508 of the ADA.
- **Health education materials, health fairs, community events**
- **Member Services Representatives**

Figure 8-7: Website communication on how to use our Nurse Call Line



Attachment 5 – Section 8.4, Question 2

Describe the credentials Nurse Call Line staff must possess.

Nurse Call Line staff credentialing

Our Nurse Call Line is a 24-hour health information line where Nurses can provide information on more than 5,000 health and wellness topics. Our Nurse Call Line staff are Registered Nurses.

Attachment 5 – Section 8.4, Question 3 [SOW 8.4]

Describe processes and protocols for when a physician must be consulted.

Consulting physicians for medical decisions

Nurse Call Line staff will follow our written protocol that specifies when we must consult a physician to respond to a call. Our Nurses operate under physician protocol that determines when to call a physician for a specific medical condition, when to refer a member to the Emergency Department, and when to call 911. Our policy is to consult with a physician when we receive calls that require a medical decision.

We will forward calls that require a medical decision to the on-call physician. The physician will provide a response to each call within 30 minutes. We document all calls in our care management system for additional Integrated Care Management (ICM) follow-up, if needed, regardless of whether the member is in ICM. We may also follow up again with members who are candidates to enroll in ICM.

8.5 Electronic Communications

Attachment 5 – Section 8.5, Question 1 [SOW 8.5] -CONFIDENTIAL

Describe how technology will be leveraged to communicate with members.

Using technology to engage and communicate with members

Aetna Medicaid Health Plans across the country are learning about the power of technology, including smartphones, and other mobile technology to engage and educate members in ways that are most accessible, comfortable, and interesting for them.

We will offer and develop a range of engagement tools focused on prevention, intervention, and overall wellness. We believe technology can help in timely and effective communication and promote member access. This will improve the member experience and quality of care.

MOBILE APPLICATION - CONFIDENTIAL

[redacted]

Figure 8-8: Sample mobile app-CONFIDENTIAL

[redacted]

FUNCTIONS FOR MEMBERS

At the most basic level, we need to give members immediate access to answers for which they might consult a member handbook or provider directory, or for which they would call Member Services. Beyond that, we need to give them relevant and usable information to make wise choices about their health care. The Aetna Better Health app will do both. Table 8-4 summarizes the functions we will provide in the app for Iowa.

Table 8-4: [redacted]

CONFIDENTIAL

[redacted]	[redacted] CONFIDENTIAL
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

	- CONCIDENTIAL

We will promote the app and explain how to install and use it. The Member Handbook and other printed member materials will describe the app. We will also promote it on the publicly accessible part of our website. As we make welcome calls and answer member services calls, the representative who speaks to the member will ask the member if he or she knows about the app and will explain how to get it, if necessary. Our Community Outreach staff will talk about the app at health fairs and other community presentations. Provider Services representatives will encourage providers to tell their patients who are Aetna Better Health members about the app. As we continue to develop our mobile application functionality, we will consider how we can offer similar kinds of information access and engagement to other program stakeholders. These stakeholders include providers, caregivers, our Case Managers, and others.

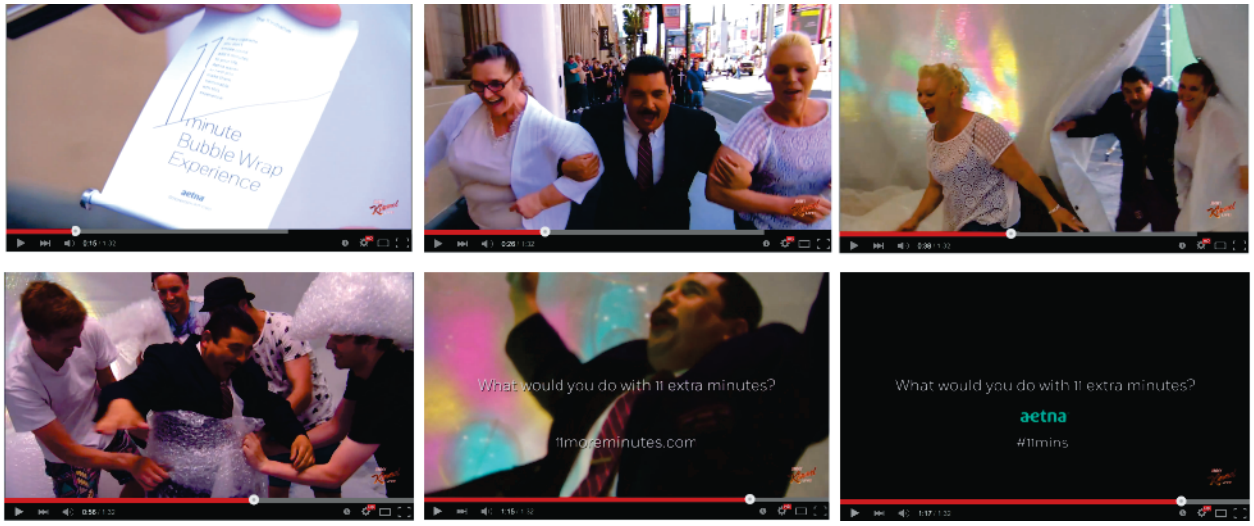
SOCIAL MEDIA

Aetna Better Health members, along with the general public, can access Aetna's social media tools, including our established Facebook, YouTube and Tumblr pages and feeds to get general health and fitness information.

One example of our Aetna's successful social media strategy is the 11 Initiative. Based on the idea that every cigarette you don't smoke can add 11 years to your life, the 11 Initiative asks tobacco users to trade a single cigarette for a surprising, memorable 11-minute experience. These fun and colorful videos appeared on Tumblr, Facebook, YouTube, Twitter and were recently featured on *Jimmy Kimmel Live*. The initiative helps people make a connection between tobacco cessation and the opportunity to live

longer, more enjoyable lives. Visit the 11 Initiative website at 11moreminutes.com. Figure 8-9 shows stills from Aetna's 11 Initiative featuring Guillermo on Jimmy Kimmel Live.

Figure 8-9: Aetna's 11 Initiative featuring Guillermo on Jimmy Kimmel Live



MOBILE TECHNOLOGY

We propose to use a suite of mobile technology solutions that will both support and expand the reach of our member education programs, and empower members to participate in managing their own health care. Our health plans have already started using mobile technology to inform and educate members and deliver personalized chronic care management programs. For example, an Aetna health plan successfully implemented Care4Life™, a diabetes-coaching program. Mobile, web-based, and interactive, this program sends text messages to program members on a variety of topics including diabetes education and support, appointment and medication reminders, and exercise and weight goal setting and tracking.

Another example of effective use of mobile technology is the text4baby™ program. We promote this free online resource for pregnant members to receive text messages on their mobile devices for reminders about prenatal care and other important health-related information. We tell our members how they can receive free cellphone minutes through programs such as Safelink Wireless®. We use this functionality to encourage pregnant members to make early and frequent prenatal and postpartum visits. We also send text4baby™ text messages to members enrolled in the program, throughout the pregnancy, and after the baby is born to remind them of appointments and provide education on topics such as the baby's growth and development, nutrition, well-child visits, and immunization.

OUR MEMBER PORTAL

Our portal features information to keep our members and caregivers informed of program features and other health-related topics. We will provide our members and providers unlimited, immediate, convenient, and no-cost access to information specific to their respective programs. The system adheres to HIPAA privacy and security requirements and Section 508 of the ADA and meets all ADA standards for people with visual impairments and disabilities. Our portal applications include many interactive functions, optimizing a user's ability to communicate and share information with members, providers, and Aetna Better Health staff.

Please refer Section 8.6, Question 1 of Attachment 5 for detailed description on the functionality and features of our member portal. We will make our website easy to find, navigate, and understand by:

- Informing our members how to access the portal (member handbook, welcome materials, and during telephone and in-person interactions)
- Making information available in both English and Spanish at sixth grade reading level
- Providing a website compliant with all ADA Section 508 requirements
- Selecting colors for optimal visual effect and comfort
- Employing responsive design, changing formats to meet the features and constraints of the member's viewing device
- Making it possible for members to increase the type size of the website for better viewing
- Providing a search-engine optimized website to allow for easy searching within the site

Acknowledgement of the requirement for electronic communications

We understand how important communication is for our members. It is even more important to transmit the information in a quick and secure manner. As discussed earlier, we will have updated information on how our members prefer to receive communication. We will respond to electronic inquires within one business day. We will use mobile technology, such as delivering medication and appointment reminders through personalized voice or text messaging. We will provide these services in our next phase of mobile enhancements.

Attachment 5 – Section 8.5, Question 2 [SOW 8.5]

Describe how information on member's preferred mode of receipt of communications will be collected and how information will be sent in accordance with such selection.

Preferred mode of correspondence

When a member contacts our Member Services Department to request a change in his or her preferred method of communication, we will honor that change.

To request a change in communication preferences, members can submit a request by telephone, standard mail, or e-mail. The Member Services Representative will provide a verbal or written confirmation on the preferred method and document the notes in the system. The information stays in the system until the member changes back to another preferred method.

When a member notifies us to receive communications electronically, we will confirm this choice through with instructions on how to change the selection. In the event a notification e-mail is returned as undeliverable, we will send a written notice by mail within three business days of the failed electronic communication. We will respond to electronic inquiries within one business day.

Attachment 5 – Section 8.5, Question 3

Describe how electronic communications will be received.

Quick and secure electronic communication

Our goal is to make health care information technology more accessible and useful to all stakeholders. This includes use of technology to communicate with members, payers, and providers.

Our Member Services helpline and Nurse Call Line staff can receive electronic communications through our secure web portal and via e-mail. We will respond to such inquiries will be responded within one business day. Communication within our web portal requires a secure password.

We will also communicate with our members using electronic media such as e-mail, our mobile app and our public website. Members will also receive text messages for HEDIS reminders and voice reminders.

8.6 Member website

Attachment 5 – Section 8.6, Question 1 [SOW 8.6]

Describe your plan to develop a member website and mobile applications in English and Spanish, and the kinds of information you will make available to members in these formats.

Web and mobile offerings – intuitive and user-friendly member experience

Our website and mobile application will serve as a valued source of information for our members, with content available in both English and Spanish. Our member portal (www.aetnabetterhealth.com/iowa) will offer members easy access to enrollment and member materials, health and wellness information, and a provider search tool. We will update and refresh provider network information daily. Figure 8-10 shows a sample home page of our proposed Iowa website, while Figure 8-11 shows an example of a Spanish-language website that is like the content we will use in Iowa.

Our user-friendly, Section 508-compliant website will:

- Be viewable on multiple devices, including desktop, tablet, and mobile, and in all major web browsers
- Be available in both English and Spanish, with instructions for requesting information in another language
- Include a Contact Us page so members can send secure messages directly to the health plan
- Include a Fraud and Abuse form to report fraud, waste, or abuse to our Compliance Department through a secure online connection; the website will also include toll-free telephone numbers to report fraud, waste, or abuse

Figure 8-10: Sample home page of our public website for Iowa

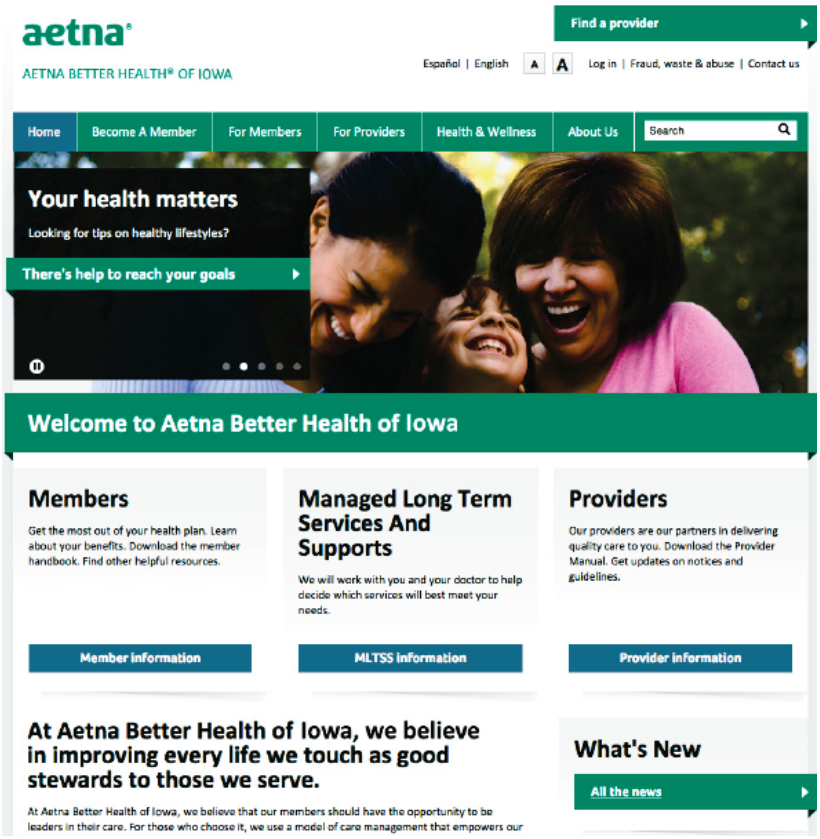
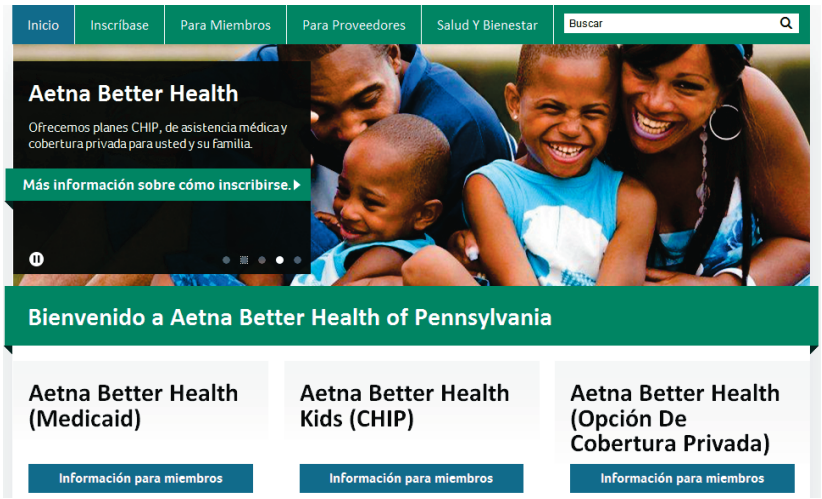


Figure 8-11: Spanish version website for Aetna Better Health of Pennsylvania



We will submit all website content to the Agency for approval before posting. The website will contain: Member handbook and newsletters

- General member service information and toll-free telephone and TDD numbers
- A network provider search function by location, specialty, and language, showing open versus closed panels
- Educational information on immunization schedules, well-child checkup schedules, and general health
- A link to the Iowa Medicaid website and toll-free number
- A link to pharmacy providers
- A list of websites with health resources
- Information on the provider and member grievance and appeals process
- A provider manual, prior authorization forms, claims submission, clinical practice guidelines, secure portal, provider training and provider services contact

Access to member eligibility or member identification information will be available only through the secure portal, which requires a user name and password. Additionally, we will provide the information required in the enrollment materials, which include:

- Health education and condition-specific information, including our disease management programs
- Information on how to enroll in a disease management program
- A link to the Medicaid website and the toll-free number
- A section for our providers that includes contact information, claims processing information, prior authorization instructions, and a toll-free telephone number for questions
- Member benefits and FAQ
- Information on filing grievances and appeals
- Instructions on reporting suspected fraud and abuse
- Information on key languages and availability of language interpretive services
- Availability of member materials in alternative formats such as audio or hardcopy
- Links to variety of public health initiatives and related materials, to promote healthy lifestyles such as healthy cooking websites and weight management programs
- Behavioral health services information
- HIPAA privacy and security policies
- Stakeholder Advisory Board minutes and information
- Plan to Publish new and updated content

Our Communications, Information Systems, and Marketing staff will be responsible for publishing new and updated content and materials, including all member portal content. These team members will use our content management system to make changes within minutes to the website. We will update provider search information nightly and update website content daily.

- **Member handbook** – The member handbook will available in both English and Spanish, with other languages available upon request. The handbook offers important information about the plan as well as instructions for contacting us and accessing benefits. The handbook is available on our public website and accessible to the members without logging into the website.
- **Provider search and provider directory** – We will update our online provider search directory nightly. These updates promote member access to the most current information.
- **Member and provider materials** – Aetna Better Health will develop innovative new materials to be published on the website. It will be the responsibility of the owners of each functional Department

to communicate changes and provide new material to the Communications staff, who then revise or replace outdated material. For example, Member Services will confirm the Member Rights and Responsibilities Statement is accurate and up to date, while Provider Services will confirm the provider manual is accurate and up to date.

INTERNAL APPROVAL PROCESS

Our review process for member and provider materials is rigorous and thorough. We engage multiple teams to provide insight and approval for all member and provider materials. These teams review content to focus on the following areas:

- **Compliance with federal and State guidelines** – Our Legal, Compliance, Member Services, Provider Relations, and Marketing Departments will collaborate to design and review the materials to confirm the member and provider materials are compliant with federal and State guidelines. We will then submit all content to the Agency for approval before publication.
- **Cultural competency** – Our Stakeholder Advisory Board will review member materials and provide feedback regarding cultural competency. The Stakeholder Advisory Board will represent a diverse background and program perspective members, their representatives (family members or caregivers), and providers. This board will provide feedback regarding strategies for improving member care and services, including health education and other member materials. Their input will allow our staff to gauge the education and health literacy levels of each audience and the ways in which culture may influence preferences or abilities.
- **Language and reading level requirements** – The Communications Department, under the direction of our Chief Operating Officer, will review content for reading level requirements to promote accessibility for members of all reading levels.

8.7 Health education and initiatives

Attachment 5 – Section 8.7, Question 1 [SOW 8.7, 8.7.1.1 – 8.7.1.12]

Describe your proposed health education initiatives including topic areas and strategies for communication. Provide sample materials.

Three Decades of Caring for Those Most Vulnerable

Aetna Medicaid has more than 30 years of experience managing the care of medically vulnerable populations, using innovative approaches to achieve both successful health care results and optimal cost outcomes. We will leverage this expertise and experience to serve the unique needs of the Iowa population.

Our staff has years of experience building and designing member educational and instructional materials for all eligible categories of Medicaid. We have learned from our experiences to create and innovate materials that work best for our members or providers. We know our members and have over the years built on the art of successful member engagement. While we focus on creating optimal education materials for specific populations, the most important aspect of health education is the structured and individualized process that our clinicians use. Motivational interviewing techniques allow clinicians to identify potential areas of education to focus and tailor to meet each member's individual needs.

Please see Appendix I for samples of our health education materials.

Health education initiatives: A holistic approach

We will collaborate with organizations that share our mission. We may team up to celebrate an event or sponsor a community health fair or have an exhibit of our own. As discussed in Section 8.1, we will

provide health education to our members and the community during health fairs and community events such as the Iowa State Fair. We will also work high-traffic community centers to share health education materials. Case Managers and community outreach staff will attend these health education initiatives. We will also include Medical Directors, depending on the forum. We will align our proposed health initiatives with the State's goals and priorities under the Healthiest State Initiative. W will also comply with protocols and implement policies and procedures to comply with the Healthy Behaviors program.

We will strengthen existing coalitions and participate in establishing new coalitions as the State's strategic priorities evolve. Table 8-5 outlines our proposed health educational materials and programs for members.

Table 8-5: Our health educational resource and programs align with Agency priorities

Section	Agency health education initiatives	Examples of educational interventions	Channel
8.7.1.1	General physical health, behavioral health, and LTSS	Online education through Krames On-Demand provides helpful information about specific conditions	Online, smartphone
8.7.1.2	Education regarding the importance of preventive care, including flu shots and age appropriate recommended screenings	Flu cards, Immunization chart mailers, growth charts	Flyers, website
8.7.1.3	Education to prepare members for participation in and reaction to specific medical procedures and to instruct patients in self-management of medical problems and disease prevention	Education through Care Management provides access to information on range of conditions	Member portal
8.7.1.4	Tobacco cessation programs with targeted outreach for adolescents and pregnant women	Tobacco cessation program	Flyers, education during events, health fairs
8.7.1.5	Nutrition counseling	Onsite Nutritionists, Adult weight management program	Flyers, education during events, health fairs, food bank events
8.7.1.6	Early intervention and risk reduction strategies to avoid complications of disability and chronic illness such as asthma, COPD, CHF, hypertension, and other conditions	National Diabetic mailer, Diabetes care checklist, Diabetes recipe book	Educational materials, in-person education
8.7.1.7	Prevention and treatment of substance use	Information on SAMHSA that includes member education	Website
8.7.1.8	Self-care training, including self-examination	Customized health assessment including health care risks, conditions, and health actions.	Digital coaching, video clips
8.7.1.9	Education to help members develop a clear understanding of how to take medications and the importance of coordinating all medications	Member health record in Active Health to track medications; Krames Educational sheets	Web-based interactive tools
8.7.1.10	Education to help members navigate the difference between emergent, urgent, and routine health conditions	*"Emergency Guide"* flyer, articles in the member newsletter	Flyers

Section	Agency health education initiatives	Examples of educational interventions	Channel
8.7.1.11	Education for members on the significance of their role in their overall health and welfare and available resources	Member newsletter articles, member welcome kit content, web portal	Member newsletters
8.7.1.12	Education for members and caregivers about identification and reporting of suspected abuse and neglect	Member newsletter articles, member welcome kit content, web portal	Member newsletters

Health education communication strategies: Encouraging self-management

Our goal is to help our members make informed choices by promoting and emphasizing the benefits of wellness and the importance of healthy lifestyles. The member initiatives we develop will apply a holistic approach to member health and wellness including exercise, proper diet and nutrition, and tobacco cessation. Our specific focus will be to increase intake of fruits and vegetables, help members to increase their quality of life by exploring areas of interest, and for working members, help them to engage successfully in activities which foster better relationships with superiors.

We honor our members' cultural and linguistic needs and preferences. We will use many methods and channels to inform and educate them about the importance of preventive health care. We will develop strong relationships with community-based organizations, advocacy groups, public agencies, and other health care industry organizations that share our vision and our commitment to our members. Our intent is to collaborate to meet the needs of our most medically vulnerable populations, as well as promoting awareness of healthy lifestyle choices that benefit all of us. We will also collaborate with other organizations to sponsor or participate in educational and informational events. Some are for targeted audiences, others are open to the public. Other educational strategies will include:

Our Get Active wellness program was introduced in 2010. This team-based fitness and nutrition program uses online social networking to encourage people of all health and fitness levels to work together with their colleagues to achieve their optimal health. The program has resulted in a 0.78-point body-mass-index (BMI) reduction (roughly 5.54 pounds of weight loss) per person across Aetna's commercial members.

- **Website** – The website will include information for members on wellness programs (including member incentives) intended to prevent chronic illnesses, promote healthy lifestyles and habits, and improve their understanding of what care is available and how to access it. The member newsletter, member handbook, and other important information will also be available there.
- **Targeted mailings** – These mailings will help our members keep up with their appointments, learn about recommended screenings, and assist with preventive measures. These mailings also explain how we deliver care and services to our members. Examples topics include childhood immunizations and EPSDT, adolescent health, prenatal and postpartum care, asthma education, well-woman screenings, ED and other urgent care choices, behavioral health services, diabetes education including diabetic eye exams, and children's dental checkups. We will also send information about any Member Incentive programs related to these topics, to members who are eligible to participate.
- **Text4baby™ Medicaid module** – This free online resource sends pregnant members text messaging, including reminders about prenatal care and other important health-related information.
- **Member newsletters** – The newsletter primarily focuses on general health information such as prevention and wellness, while specifically addressing actions members can take to meet their goals of promoting wellness, improving health status, and achieving a higher quality of life. Member

newsletters also address the appropriate use of the ED, the importance of a PCP or Patient-Centered Medical Home (PCMH), and the importance of keeping scheduled visits. Newsletters have change-of-address reminders, program benefits, and other topics to address member behavior. These topics will include healthy eating tips, healthy pregnancy, domestic violence awareness and prevention, seasonal information like flu prevention, and the importance of well-child visits.

- **Program brochures and flyers** – These materials contain specific and targeted information about prevention and wellness programs. We will distribute these materials at community events.
- **Krames On-Demand®** – This online education service will provide our members helpful, easy-to-understand information sheets on common health conditions such as asthma, diabetes, and pregnancy. Geared to encourage members to work toward self-management goals, this resource is also available to members on any Internet connected device, including smartphones.
- **Ted E. Bear, MD™ for Iowa** – Popular events featuring Aetna's own Ted E. Bear, MD create a dynamic collaboration of our team members, local health care providers and non-profit health care disparity organizations to increase health literacy and address local health care disparities in a festive health fair setting (Figure 8-12). Past examples of these programs have included the Ted E. Bear Garden, which partners team members with local growers, community gardens, and local health care providers to increase access to fresh food and provide nutrition and meal strategies education. Another recent program was the Ted E. Bear Picnic program, which partners our team with local childcare providers and faith-based and other non-profit organizations to provide an engaging program that teaches children and families about healthy eating and being active.

Figure 8-12: Our popular Ted E. Bear, MD programs engage kids and families

- **Education for hard-to-reach members** – We will provide educational materials during health fairs, church events, and religious gatherings. We may also collaborate with Federally Qualified Health Centers (FQHCs) for baby showers and programs for asthma, postpartum health, diabetes, and weight management.

Our sample member education materials

Please see Appendix I for samples of our member education materials.

Attachment 5 – Section 8.7, Question 2

Describe how you would propose to participate and interface with the Healthiest State Initiative.

Healthiest State Initiative: Working toward a shared vision and goal

Building from experience strengths, we will serve as a change agent to champion ongoing advancement by cultivating a person-centered, team-based, coordinated, and integrated model.

We are fully aligned with the five focus priorities:

- Decreasing the number of Iowans who smoke
- Increasing consumption of fruits and vegetables
- Increasing the number of Iowans who are learning or doing something interesting daily
- Increasing the number of Iowans who have visited the dentist in the last year
- Increasing the number of Iowans who feel their boss treats them like a partner at work

Our response to section 10.2.3 discusses in detail our plan to work with the Agency on this initiative.

Community Crops and our Nebraska plan have a shared mission to address food deserts in Lincoln, Nebraska, to help make Lincoln a healthier community. To get the program off the ground, Aetna Foundation awarded the group a $25,000 GoLocal - Cultivating Healthier Communities grant to help Lincoln residents grow their own fresh produce. The harvested food helps fulfill local nutritional needs that would otherwise go unmet.

Since 2003, Community Crops has worked with Lincoln communities to convert unused space into productive gardens that annually produce more than 14 tons of fresh, healthy fruits and vegetables. We will bring the same commitment and program to our Iowa communities.

8.8 Cost and Quality Information

Attachment 5 – Section 8.8, Question 1 [SOW 8.8]

Describe proposed strategies to provide price and quality transparency to members.

Our strategy to provide price transparency to members

We believe our members should have a greater understanding of costs, such as the cost per visit to the Emergency Department compared to PCP. This level of understanding will help members make a conscious decision to use a particular service when given an option. We will give our members cost and quality information to empower them to make informed decisions about the care they receive and where they receive it.

National Medicaid Quality Management (NMQM) is working with Aetna Information Systems to develop a financial calculator which will be available January 1, 2016 (Figure 8-15). Our members will be able to determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution, as applicable.

The financial calculator will:

- Provide pricing for all services available to members.
- Communicate that such information does not constitute approval or authorization for the service.
- Provide an interactive tool that allows members make specific queries.

We will not be required to consider members' deductible or out-of-pocket maximum expenses when estimating financial responsibility. We will communicate this to members and explicitly state the difference in financial responsibility between in-network benefits and out-of-network benefits, and that members may be responsible for charges above approved rates.

Figure 8-15: [redacted] CONFIDENTIAL

[redacted]

Our strategy to provide quality transparency to members

We will make our HEDIS and CAHPS scores available to our members online and upon member request. More than 90% of America's health plans use HEDIS to measure performance on important dimensions of care and service. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. The CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. Table 8-6 shows a selection of the available topics for which members can view our scores:

Table 8-6: Examples for HEDIS and CAHPS measures

Examples of HEDIS measures	Examples of CAHPS measures
• Asthma Medication Use • Persistence of Beta-Blocker Treatment after a Heart Attack • Controlling High Blood Pressure • Comprehensive Diabetes Care • Breast Cancer Screening • Antidepressant Medication Management • Childhood and Adolescent Immunization Status • Childhood and Adult Weight/BMI Assessment	• Access to Care • Utilization • How well doctors communicate • Confirmation of enrollment/coverage • Plan administration • Health status • Mental and emotional status • Screener items for patients with chronic conditions

Attachment 5 – Section 8.8, Question 2 [SOW 8.8.1]

Provide sample EOBs as an exhibit or attachment.

Our sample copy explanation of benefits

Please see Appendix J for a sample EOB.

We will provide EOBs or a statistically valid sample available via paper and secure web-based portal according to our members' preferred methods of communication. The EOB will address requirements in 42 CFR 433.116(e) and (f). We will not send EOBs on family planning services.

Attachment 5 – Section 8.8, Question 3 [SOW 8.8, 8.8.2]

Describe processes for making provider quality information available to members.

Our process to share provider quality data with our members

We will provide quality information on our network providers to all members—including access to provider credentials such as education, accreditation, and board certification—in our provider directory. The directory will be available online and in hard copy and can be made available in multiple languages.

8.9 Advance directive information

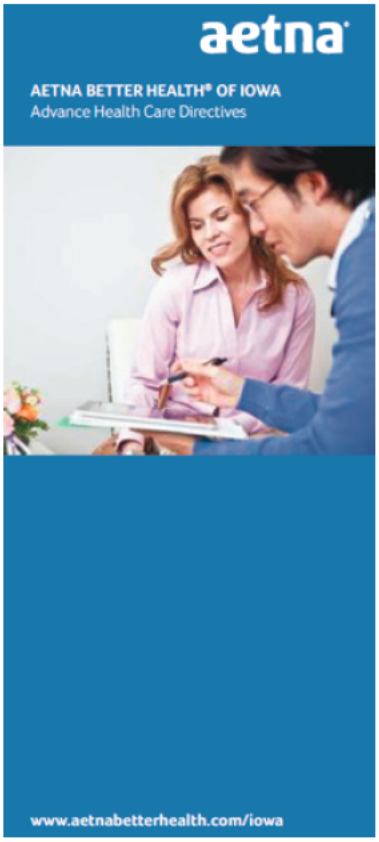
The Contractor shall comply with the advance directive requirements outlined in Section 8.9.1 and Section 8.9.2 below.

Policies and procedures [SOW 8.9.1]

Our policies and procedures on advance directives will follow Subpart I of 42 CFR 489. We understand the Advance Directive as defined in the Section 42 CFR 489 is a written instruction such as a living will or a durable power of attorney for health care.

Our documented Advance Directives Medicaid policies and procedures provide guidance on our obligations to educate members about their rights to make informed decisions about their health care. We will include information related to advance directives in our member handbook and provider manual. Case Managers will discuss advance directives during the initial case management assessment with the member. We will also have desktop procedures that describe how to facilitate dialogue with members regarding health care directives and how to document each member's wishes.

Figure 8-16: Our Advance Directive brochure



All members have the right to discuss, clarify preferences, and proactively provide direction for care in the event they become unable to personally provide that information at a future point in time. Types of conditions that could render members unable to provide real-time direction for their care include coma, brain injury, life support, and potential resuscitative actions. Additionally, all members have the right to designate someone of their choosing to speak on their behalf in such circumstances. The desktop procedures will outline the care management process for assisting members in implementing their personal health care wishes.

Our Contract Administrator will be responsible for activities necessary to train staff and administer this policy. The advance directive measures will apply to Member Services, Provider Relations, Quality Management, and Medical Management, as

well as any other staff who have direct member contact. The policies also apply to participating practitioners and providers.

Our Quality Management (QM) Department is responsible for reviewing the policies of participating institutional facilities (such as skilled nursing facilities and hospitals) during routine site audits and surveys. QM documents compliance or non-compliance with advance directive requirements in site audit or survey records or reports. Furthermore, QM will also verify that participating practitioners and providers, including PCPs, have placed or included a member's executed advance directive in the member's medical record during routine ambulatory medical record reviews. QM will document compliance or non-compliance with advance directive requirements during site audits or through survey records or reports.

Provider Services will be responsible to determine if a practitioner or provider has adequate and appropriate office procedures related to this policy during the pre-contract and site visits. Participating practitioners and providers will not be required to implement an advance directive if, as a matter of conscience. Complaints concerning noncompliance with advance directive requirements may be filed with us as a grievance. Additionally, our provider service staff educates and monitors provider compliance with the advance directive documentation requirements during onsite medical record reviews and provider orientation. We will provide advance directive training to our staff that has direct contact with members.

Providing notification of advance directive decisions [SOW 8.9.2]

If a member is incapacitated at the time of initial enrollment and is unable to receive information or articulate that he or she has executed an advance directive, we will provide the information to the member's family or surrogate. In the event any written information has to reflect regulatory changes, we will notify members no later than 90 days after the effective date of the change. We will also share our Advance Directive brochure (Figure 8-16) with members or caregivers as needed.

Here is sample language from our member handbook:

> ***Medical Care Decisions: What If I Am Too Sick to Make a Decision About my Medical Care? What Are Advance Directives? How Do I Get an Advance Directive?***
>
> *An advance directive is a written statement that you complete before a serious illness. This statement tells how you want medical decisions made. If you can't make treatment decisions, your doctor will ask your closest relative or friend to help you decide what is best for you. Sometimes everyone doesn't agree about what to do. That's why it is helpful if you tell us in advance what you want to happen if you can't speak for yourself.*
>
> *If you do not have an advance directive and you would like more information on how to get one, call us at the toll-free number on your ID card. We will be glad to help you.*
>
> *Additionally, we will inform members that complaints concerning noncompliance with the advance directive requirements may be filed with the State.*

8.10 Member rights

Attachment 5 – Section 8.10, Question 1 [SOW 8.10,8.10.1-8.10.9]

Describe your process for ensuring member rights as described in Section 8.10.

Communicating and protecting member rights

Our policies and procedures will include the following member rights per Section with 42 CFR 438.100 and State requirements:

- Receive information
- Maintain dignity and privacy
- Receive information on available treatment options
- Participate in his or her health care decisions and exercise the right to refuse treatment
- Be free from any form of restraint or seclusion
- Receive a copy of his or her medical record
- Provide treatment in the least restrictive setting
- Participate in the community and to work, live and learn to the fullest extent possible
- Be furnished health care services per 42 CFR 438.206 through 438.210

Our staff and network of providers will have a copy of the policies. We will have a process in place to ascertain that our staff and providers are considering members' rights during health services delivery. We will not discriminate against members who choose to exercise their rights and will follow the regulation set forth under 42 CFR 438.100.

Our process is to make certain all members understand are well informed of their rights and responsibilities by presenting this information in a way that is accessible by all and in a language and format that meets the needs of every member. We will keep the information up to date and compliant with the State and federal guidelines and make certain the information is accurate, easily understood, and in plain language.

We will use the member handbook, member newsletter, and website to notify members of their rights. Under the direction of the Contract Administrator, Member Services is responsible for publishing member rights in the member handbook. The Provider Services Department will publish member rights and responsibilities in the provider manual. Annually, we will distribute the member handbook and provider manual, which include member rights information, to members and participating providers.

LTSS

We acknowledge additional rights for long term care members who are residing in a nursing facility: Receive considerate, respectful, and appropriate care, treatment, and continuity of care

- Choose a personal attending physician
- Not be transferred or discharged out of a facility except for medical reasons, welfare of yourself and others or the; or for non-payment of justified charges
- Respect, privacy, be free from restraints
- Make choices regarding activities, schedules, health care and other aspects of your life
- Participate in an ongoing program of activities and social, religious and community activities
- Receive a timely, courteous and reasonable response
- Associate or communicate with others without restriction
- Manage your own financial affairs
- Recommend changes or present grievances to the facility staff, the Ombudsman, or others
- Be free from verbal, physical, or mental abuse, cruel and unusual punishment, involuntary seclusion, withholding of monetary allowance, withholding of food, and deprivation of sleep
- Receive notice before your room or roommate is changed, except in emergencies

- Receive, prior to or at the time of admission, a written statement of the services provided
- Receive a written itemized statement of charges and services
- Receive from the attending physician complete and current information concerning your diagnosis, treatment, and prognosis
- Inspect all records about you
- Have the facility place at your bedside, name, address, and telephone number of the physician responsible for your care
- Receive, in writing, information regarding any relationship the facility has with other health care or related institutions or service providers

We will measure the effectiveness of the policy and its execution by tracking and reporting the number of grievances received on member rights issues.

8.11 Redetermination assistance

Attachment 5 – Section 8.11, Question 1 [SOW 8.11, 8.11.1, 8.11.2]

Describe in detail your plans to assist members in the eligibility redetermination process and control against prohibited activities.

Assisting our members in eligibility redetermination

We will meet the State guidelines by following the redetermination activities and will:

- Contact members by telephone or will send letters reminding them to renew their eligibility
- Review redetermination requirements with the member on the telephone as needed
- Answer questions about the redetermination process
- Help the member obtain required documentation and collateral verification needed to process the application

We will assist members in the eligibility redetermination process through the following channels:

- **Member Services Helpline** – Our members can call our Member Services helpline to receive eligibility redetermination assistance from our Member Services Representatives. If our Member Services Representatives are unable to assist the member or the question is outside of their scope, they will redirect members to the Enrollment Broker.
- **IVR calls** – We will conduct automated IVR calls reminding members of their eligibility redetermination.
- **Member handbook** – The member handbook will include the toll-free number for the Agency's contact center to request the eligibility form.
- **Member portal** – Members can get more information on our interactive and user-friendly member portal. We will provide a link to the State website where members can receive more information on eligibility redetermination. Members can also view their eligibility status on the member portal.

Maintaining control on prohibited activities

We also understand that during eligibility redetermination we:

- Cannot discriminate against members for any reason
- Will refer members who ask about changing contractors to the Enrollment Broker
- Will not discuss eligibility status with members

- Will not engage in or support fraudulent activity while helping the member complete the redetermination process
- Will not sign the member's redetermination form
- Will not complete or send redetermination materials to the State on behalf of the member

8.12 Member and stakeholder engagement

Attachment 5 – Section 8.12, Question 1 [SOW 8.12]

Describe in detail your member and stakeholder engagement strategy.

Member and stakeholder engagement builds stronger, healthier communities. Drawing from our successful best practices building engaged member and stakeholder populations in Arizona and Illinois, we will use a Stakeholder Advisory Board structure to give members and stakeholders a voice and integrating their feedback throughout our policies, processes, and operations.

Our member engagement strategy

Our member engagement strategy focuses on how our staff connects with members, how members connect with our programs, and how we are involved in our communities. Our member engagement strategy focuses on using multiple channels to meet members where they are: In the community, at home, and connecting online. These channels include:

- Member materials
- Bilingual website
- Member portal
- Mobile technology
- Interactive voice response
- Community events

MEMBER MATERIALS

We have a wealth of health and wellness information to share with our members to support member education, access to program resources, and self-direction. From our member handbooks, to mailings, to reminder postcards and brochures, we understand our members' needs and will develop customized materials suited to their individual needs, as described in Sections 8.2 and 8.7.

BILINGUAL WEBSITE

Our interactive, bilingual website will provide rich content on health and wellness for pregnant women, children, special needs, health resources, extra programs and services, and other. Our response in Section 8.6 provides additional details on the information available to our members in English and Spanish.

MEMBER PORTAL

The member portal will provide the member access to personal health records, health assessment, disease management, and online lifestyle coaching. Members can engage with variety of information that helps promote education and self-direction. Additionally, the health assessment section encourages members to assess their current health, history, and lifestyle habits.

SOCIAL MEDIA

Committed to Health Care Transformation

Aetna Better Health members can take advantage of Aetna's national social media presence that the format that is most meaningful to them. Aetna's national social media platforms include Facebook, Twitter, YouTube and Tumblr, and all contain messaging targeting different populations with a shared interest in a particular topic, such as diet or fitness.

Figure 8-17 is a tweet from the Food Bank of Iowa, thanking us for our partnership last summer.

Figure 8-17: Social media builds awareness and engagement

MOBILE TECHNOLOGY

Aetna Medicaid offers free mobile phones and health messages to Medicaid members. Eligible Medicaid members receive a free cell telephone with 250 free minutes per month and unlimited text messages. In addition to the cell telephone, members receive personalized text messages that encourage healthy behaviors. Calls to Member Services do not count toward the member's minutes. Any member can sign up for this new program anytime. More than 26,000 members in our Maryland plan have used these services. Table 8-7 provides the various programs members can use.

Table 8-7: Effective mobile technologies to engage members to receive preventive care

Program	Target population	Content resources
Text4baby	Pregnant women and new parents through baby's first year	Text4baby sends timely health tips through pregnancy and baby's first year including reminders for prenatal/postpartum appointments, immunization, safe sleep, labor and delivery, and more.
Text4Kids	Parents of children ages 1-18	Text4kids sends helpful text messages based on a child's age and development. Parents of children between the ages 1-3 will get about three messages per week. As your child gets older, they get fewer messages. Text4kids provides tips on what to expect with a child's development, reminders for appointments and immunizations, and much more.
Text4Health	Adults over 18 years old	When members sign up for Text4health, they will answer a few questions that will help to build a health profile. Text4health will send about one message per week based on the answers. Member can get more by choosing to play fun health quizzes or trying a 30-day healthy challenge.

INTERACTIVE VOICE RESPONSE

To make it easy for our members to keep up with health appointments, we provide Interactive Voice Response (IVR) reminders for services such as preventive care, prenatal care, diabetes care, or other. The IVR is a natural human scripted voice call. There is also an option to connect to a live person. Additionally, we send text message reminders such as, "See the doctor," "Get a Mammogram," or "Time to reapply for medical assistance."

COMMUNITY EVENTS

Our community outreach efforts will aim to help improve health outcomes by educating the community on important health topics and increase brand awareness to grow and retain membership. We will use several outreach tactics to achieve these goals. Our community outreach department plans to participate several events in our first year, including health fairs, community events, workshops, seminars, and grand openings. They will also engage church faith groups to contact hard to reach members.

One example of a recent community event in Iowa was a collaborative effort of Food Bank of Iowa, Coventry Health, Aetna Foundation, and several community organizations to offer fresh produce to Iowa households every week last summer from June 11 – August 13 (Figure 8-18). Together, we reached nearly 2,000 households. Participation was free of charge and there were no income eligibility guidelines to participate.

Figure 8-18: Local community outreach efforts - Food Bank of Iowa

Our stakeholder engagement strategy

We will build relationships through membership in coalitions to support community health initiatives based on the State's strategic priorities and to respond to the specific needs of each community. Under the new Contract, we will strengthen existing coalitions and participate in establishing new coalitions as the State's strategic priorities evolve.

We are collaborating with doctors, hospitals, pharmacies, labs, employers, members, and others to build a simpler, more integrated system centered on the individual. Our focus and incentives will improve member health by increasing quality, access, and value. We have executed our five-point strategy and expanded access to care through strategic collaborative efforts within counties and local communities, including:

- **Mapping to shared goals –** In the counties and communities where our members live, we will search for alliances and collaborations with organizations that share our common goals for improving member health outcomes.
- **Demographic analysis –** We will analyze the demographics of our various service areas in terms of race, ethnicity, and language, identifying potential barriers our members may experience due to

those backgrounds. We will also review HEDIS statistics for our membership in those areas to identify what gaps in health services we need to address.

- **Identify gaps, seek allies to fill them** – Using the demographic information we gather, we will closely align our strategy with specific community groups who share goals for health outcomes, providing enhanced access to targeted health services from providers who understand the diverse cultural groups in that community.
- **Track economic trends** – We will also track the economic and industrial trends in these counties and communities, as changes to these dynamics can quickly shift resources and affect our members' ability to access services. When this occurs, we will reassess and add alliances or increase or decrease emphasis with existing alliances, as necessary.
- **Effectiveness reviews** – We will conduct semi-annual effectiveness reviews to identify member and community disparities. We also work with a cross-functional HEDIS Improvement Workgroup to link our work with results that help us identify gaps in care for specific counties and communities. Because of our review of this data, we will develop revised initiatives, then implement and monitor them.

The goal of our outreach campaign in Illinois was to engage the local advocacy community, which was concerned about the change from a fee-for-service delivery system to a managed care delivery system for the ICP population.

OUR EXPERIENCE IN ENGAGING STAKEHOLDERS - PROGRAM IMPROVEMENTS

In 2010 and 2011, our Illinois plan launched an advocate relations campaign as part of our implementation of the Integrated Care Program (ICP) contract. The ICP serves seniors; individuals in the aged, blind, and disabled aid category; and populations with intellectual and developmental disabilities who are not eligible for Medicare. The goal of the campaign was to engage the local advocacy community, which was concerned about the change from a fee-for-service delivery system to a managed care delivery system for the ICP population. We wanted to answer their questions about managed care and help them understand more about the person-centered approach to Integrated Care and Services Management. The health plan held a series of public meetings, each targeting a specific stakeholder segment, such as behavioral health advocates and providers, home and community-based providers, community resource groups, and members and their families. Anyone with an interest in the ICP was welcome to attend.

These meetings took place at community centers throughout the six-county service area. Health plan leadership attended each of the sessions to personally answer attendees' questions about the ICP and the health plan's philosophy and operations. Although the events were held during a winter that saw a record number of blizzards, attendance was good at all five events. The health plan later facilitated a series of live webinars to engage stakeholders who could not attend the community meetings.

Advocates and other stakeholders noted that Aetna Better Health of Illinois was the only ICP contractor that took the time to interact with them before operations. They praised our efforts to collaborate with them, listen to their concerns, and understand their priorities for their constituencies.

Attachment 5 – Section 8.12, Question 2 [SOW 8.12, 8.12.1, 8.12.1.1, 8.12.1.2, 8.12.1.3, 8.12.1.4, 8.12.1.5]

Submit your Stakeholder Advisory Board strategy and discuss how meaningful representation from member stakeholder groups will be ensured.

Stakeholder Advisory Board strategy

Explore Ideas to Make the World a Better Place

We will create and facilitate a Stakeholder Advisory Board within 90 days of an executed Contract between the Agency and Aetna Better Health. The purpose of the Stakeholder Advisory Board is to serve as a forum for members or their representatives and providers to advise the health plan.

The Stakeholder Advisory Board will provide input on issues such as service delivery, quality of care, member rights and responsibilities, grievances and appeals, operational issues, program monitoring and evaluation, member and provider education, and other issues identified by members.

We will submit a plan to the Agency for the Stakeholder Advisory Board, subject to the review and approval of the Agency. The plan will include procedures for implementing the Stakeholder Advisory Board and details discussing how we will provide meaningful representation from member stakeholder groups. We will maintain written documentation of all attempts to invite and include members in the Stakeholder Advisory Board meetings. We will also maintain meeting minutes and will be made available to the Agency upon request.

We will promote member participation and make necessary arrangements for members to attend. We will facilitate member transportation, interpretation services, and personal care assistance. The Stakeholder Advisory Board will meet quarterly at a central location. Aetna will advise the Agency of all meetings at least 15 calendar days in advance. Some proposed agenda topics include:

- Survey results of Aetna Better Health Quality Improvement staff
- Feedback from members or Aging & Disability Resource Connection/Area Agency on Aging
- Input regarding potential new programs
- Presentations from community agency regarding resources available to members

Stakeholder Advisory Board membership

Each state has its own unique service area and groups of stakeholders who play a significant role in shaping the Medicaid program. Recognizing and respecting this diversity, we will implement a Stakeholder Advisory Board that will include broad representation from Iowa's community stakeholders. We will seek out members who may be interested in joining the board. We will also work with community organizations and advocacy boards to refer members. We will structure the membership of the Stakeholder Advisory Board to include:

- Members or representatives (for example, family members or caregivers) who will constitute at least 51% of the membership
- Representatives of nursing and behavioral health facilities, hospitals, primary care associations
- Representatives of HCBS providers, including community-based residential alternative providers such as assisted living facilities and home care agencies, and 1915(i) habilitation providers
- Aging & Disability Resource Connection/Area Agency on Aging (ADRC/AAA)
- Local advocates whose constituencies are served by the Iowa High Quality Healthcare Initiative

One important source of membership will be Iowa's community-based organizations that are working to address clearly identified concerns within the community: Mental health and substance use, transportation and meal services, homelessness, employment support for adults with disabilities, support for caregivers and families, volunteer recruitment and deployment, availability of vaccines, and

educational and summer programs for children. The valuable insight of these organizations plays a substantial role as we plan our approach.

Attachment 5 – Section 8.12, Question 3 [SOW 8.12.1.6]

Describe how feedback obtained from the Stakeholder Advisory Board will be utilized.

Applying Stakeholder Advisory Board feedback: We listen, we learn, we change

As part of our work with the organizations described above, we will routinely collect data about the impact of specific programs and activities on the State's health care initiatives in both rural and urban counties. We will provide feedback as requested by the State, using information from formal surveys, focus groups, regular and ad hoc meetings, and informal interactions. We plan to use feedback from all stakeholders to work with our community, region, and the State to review and revise strategic plans, update and enhance programs and materials, and report to interested parties.

We will incorporate feedback obtained from the Stakeholder Advisory Board when we develop and implement process improvement strategies and make changes to policies and procedures as needed. We will incorporate issues raised by stakeholders into quality assessment and performance improvement program and into our operational planning and management activities.

For example, our Member Advisory Council (MAC) surveys through our health plans revealed that transportation was the most underutilized and least understood benefit. During MAC and Community Partner Advisory Council (CPAC) meetings, we developed plan to increase member awareness and access. This collaboration improved member materials and services by:

- Revising the transportation brochure
- Setting health care appointments and booking transportation while the member is online with Member Services or clinical staff,
- Using the Member Services call script to remind members of mileage reimbursement benefits and provide instructions on how to maintain a transportation log

To Whom It May Concern/State of Delaware:

I am writing to express my strong support for the Medicaid Advisory Committee (MAC), of which I am a member. Being included in this committee is quite important to me for several reasons. It's important to me to be part of Aetna's decision-making process regarding various aspects of Delaware Physicians Care. As a Medicaid consumer on several levels, I recognize the benefit of being there, live, as decisions are being considered; it gives me a voice in the otherwise anonymous (and often demeaning) system that directly impacts my own health care and the health care of others. The MAC allows me to be directly involved, which improves my sense of self-esteem and self-efficacy. Unable to work, I am at least able be part of a business-related group, which is vital to my sense of usefulness in the world.

I also think it's important to have an MAC as a sort of check and balance system. We are able to give Aetna real-time, real-life information and feedback concerning our health insurance. Without this check and balance in place, Aetna (and therefore Delaware Physicians Care) would be gravely out of touch with us, the consumers, and may inadvertently end up making decisions that could impact us negatively. They sincerely care about how we are impacted, and it is good business strategy, if nothing else, to actively include the consumer's opinions. Otherwise, you would be left with just a survey system, which would not capture our responses as effectively or personally. (When I was able to work, one of the things I wish we had done at our behavioral health company, as a manager, was to have a group comparable to MAC; it would have improved our performance and allowed us to tailor services in a more meaningful way).

In sum, I am happy to be a MAC member. I look forward to our meetings because the discussions are always informative, they allow members to connect with each other, they provide a respectful and gracious forum for us to express our opinions and experiences with Delaware Physicians Care, and they are vital to Aetna's continued growth as a provider of Medicaid.

Thank you for your time. I would be happy to provide any further information regarding MAC.

8.13 Stakeholder education

Attachment 5 – Section 8.13, Question 1 [SOW 8.13]

Describe your plan for stakeholder education including proposed timelines and topics.

Our stakeholder education plan

We will develop a formal process for ongoing education of providers, advocates, members, families, and caregivers before, during, and after implementation of the Contract. In fact, we have already begun meeting with many stakeholders in Iowa and previewing our processes. We have started to identify and solidify the relationships that will be the most promising foundations for collaborative projects, shared sponsorships, and ongoing collaboration on many individual activities.

We will publicize methods members can use to ask questions about the program. Typically, we broadcast our education plans at health fairs, events, and other community activities. We will submit a stakeholder education plan to the Agency for review and approval in the timeframe and manner determined by the State. Figure 8-21 identifies some high-level timeframes and stakeholder education topics. Our Member Services staff will be available during and after implementation to answer any plan-related questions. Our Provider Services staff will contact providers to assist with provider onboarding

and education. Our business development staff is already on the ground meeting and educating with various community and advocacy organizations.

Figure 8-21: Our planned dates to begin stakeholder education with sample educational topics

Member and Caregiver Education *Starts prior to go live and continues through the life of the contract*	• Health education and wellness • What is managed care? • Aetna products and benefits
Provider Education *Starts prior to go live and continues through the life of the contract*	• Claims processes • Access and availability • Provider forum and training
Community & Advocacy Organizations' Education *Starts prior to go live and continues through the life of the contract*	• Community outreach plan • What is managed care? • Aetna community programs

Continuous education through engagement

We will use a formal process to educate stakeholders during implementation. We consider our stakeholders to be those who have any direct or indirect contact with our members, such as providers, advocates, and members' families and caregivers. We will engage our stakeholders by asking questions and seeking their advice and guidance on the program. Our intent is to customize the program to the needs of Iowan population, thereby meeting our goals to improve access and quality.

Attachment 5 – Section 8.13, Question 2 [SOW 8.13]

Describe how you will identify and outreach to stakeholders.

Our plan to identify and outreach to stakeholders

Our approach is to identify and contact stakeholders to develop mutually beneficial relationships that advance overall community development. Our stakeholder identification and engagement approach aligns with Agency goals. We aim to improve access, quality of care, and impact health care costs with our comprehensive and thoughtful approach to collaboration.

There is no more powerful aid in the design, development, and delivery of effective, culturally competent member education and outreach programs than collaboration with stakeholders who share our goals, objectives, and values. We have been listening to and learning from Iowans about what members need and want from the High Quality Healthcare Initiative.

Our webinar for the Leading Age, a non-profit nursing home association with 80 members, introduced Aetna and our experience collaborating and contracting with nursing facilities.

PROVIDERS AND ADVOCATES

We have made significant progress in reaching out to key stakeholders across the state. We have learned about the priorities and programs the stakeholders are working on. Highlights of opportunities for future engagements include:

- **Iowa Primary Care Association** – Collaborating to support their Accountable Care Organization development; providing training on behavioral health and primary care.
- **Association of Area Agencies on Aging** – Collaborating and considering contracting for services such as case management, assessments, care coordination, home health, and transportation.
- **Iowa Behavioral Health Association** – Seeking opportunities to collaborate on a behavioral health network; helping support the integrated health home and move to expand it.
- **Iowa Medical Society** – Collaborating on education and addressing the move to managed care through their website.

MEMBERS AND CAREGIVERS

We will work with the community organizations to identify our member stakeholders and proactively seek out for names and references.

8.14 Implementation Support

Attachment 5 – Section 8.14, Question 1 [SOW 8.14]

Describe proposed strategies to support members during program implementation.

Supporting members during implementation for a smooth transition

Listen, Respect, and Act with Insight, Understanding, Compassion

To facilitate member transitions and continuity of care, Aetna Better Health will see that **all** members receive optimal, uninterrupted health care, regardless of whether they enroll as new members or are transferring from Fee-For-Service (FFS). Our plans have a history of success in facilitating compassionate and efficient care transitions for members with acute and chronic health conditions.

For transitioning members, our policies, processes, and procedures will allow them to continue with the Medicaid services they had been receiving with both in network and out-of-network providers at the time of enrollment with our plan. Throughout the transition period, we will **promote the member's dignity** and **acknowledge and respect the member's culture** while maintaining confidentiality. We will also continuously engage providers who may currently be providing care to our new members.

We have successfully implemented managed care programs for 30 years. We know what is required to efficiently, effectively, and successfully plan and implement changes. We have experience implementing systems, processes, and procedures will improve our ability to deliver exceptional integrated care. Aetna Medicaid's experience—years of improving the health and well-being of 3 million Medicaid members in 17 states—is now fully available in Iowa. We look forward to demonstrating the advantage to our members, providers, and the State.

OUR EXPERIENCED TEAM ALLEVIATES TRANSITION RISK

We are committed to providing the resources needed to successfully support and operate the Iowa High Quality Healthcare Initiative Managed Care program. Local leadership and resources will lead the project and national Aetna Medicaid resources will provide support as needed. An experienced Medicaid

Implementation Manager will have responsibility to lead a cross-functional team of our experienced management staff, Aetna Medicaid support staff, and subcontractor staff in executing the tasks outlined in the Implementation Plan. As a result, the implementation will transition seamlessly into day-to-day operations.

Our process to facilitate effective service continuity for members includes the following specific tasks and activities:

- **Identify members with special needs –** We will prioritize the identification of members with special health care needs, including those who need special assistance during the transition to maintain continuity of care. These members may currently be in treatment for acute or chronic conditions, diagnosed with a serious mental illness, or receiving services that require authorization. Our case managers will work closely with these members, their families, and providers to support continuation of the process.
- **Initiate and maintain active communication –** Our Case Managers will initiate communication with all known entities involved in a member's transition. This includes providers and facilities, family members, other caregivers, and any involved supportive services. Case Managers will contact providers of both covered and non-covered services to facilitate an effective transition and obtain all available, relevant information regarding the member's care, as permitted under confidentiality provisions. We will also facilitate coordination between all parties involved in delivering care to the member to effect a smooth transition.
- **Provide uninterrupted access –** We will focus on the completion of any previously initiated course of treatment, such as ongoing behavioral health services being provided by a PCP. We will also work to maintain established member-provider relationships, including patient-centered medical homes, PCPs, and other treating providers, during the transition period and on an ongoing basis as appropriate. If necessary, we facilitate referrals and assignments to new providers and work with the member and provider so that these referrals are acted upon and the member is receiving care from the new provider.
- **Assess ongoing member care needs –** Our goal is to make certain members receive necessary services in a supportive, effective, efficient, timely, and cost-effective manner. As necessary, we will work with a member and his or her providers to develop an individualized transition Care Plan, described below, that emphasizes prevention and continuity of care, and addresses the member's needs, goals, and preferences.
- **Monitor the continuity and quality of care –** We will frequently monitor services for continuity and to evaluate the quality of care being provided to the member during and after the transition period, taking immediate action to address any disruptions in care or identified quality issues.

8.15 Grievances, Appeals, and State Fair Hearings

Attachment 5 – Section 8.15, Question 1 [SOW 8.15, 8.15.1, 8.15.2, 8.15.3, 8.15.4, 8.15.5, 8.15.5.1, 8.15.5.2, 8.15.5.3, 8.15.5.4, 8.15.5.5, 8.15.5.5.1, 8.15.5.5.2, 8.15.5.5.3, 8.15.5.5.4, 8.15.5.5.5, 8.15.5.5.6, 8.15.5.5.7, 8.15.6, 8.15.6.1, 8.15.6.2, 8.15.6.3, 8.15.6.4, 8.15.6.5, 8.15.7, 8.15.7.1, 8.15.7.2, 8.15.7.3, 8.15.7.4, 8.15.8, 8.15.8.1, 8.15.8.2, 8.15.8.3, 8.15.8.4, 8.15.8.5, 8.15.8.6, 8.15.8.7, 8.15.8.8]

Describe in detail your system for resolving inquiries, grievances, and appeals, including how your system ensures all policy and processing requirements are met.

Resolving member inquiries, grievances, and appeals

Our goal will be to make members' lives easier and not burden them with undue administrative challenges. We will make certain that our members are provided education through multiple avenues on their right to file a grievance or appeal with Aetna Better Health. We will provide members with thorough and accurate information regarding grievance and appeal processes and procedures. We will communicate with members respectfully, catering to the individuality of each member.

Members or their representatives will be able to file a grievance or appeal directly with Aetna Better Health in writing by mail, e-mail, fax; verbally through our toll-free Member Services number; or to any health plan staff member. We will never take punitive action against a provider for acting on a member's behalf in filing a grievance or requesting an appeal.

To help members navigate the process, Member Services Representatives, Grievances and Appeals staff, or other staff will provide assistance in explaining the process and forms, completing forms, or help the member take other procedural steps. We will provide interpreter services and alternate formats as needed at no cost to the member. If a member requests assistance, we will assign a staff member to help him or her throughout the grievances or appeals process.

INFORMING MEMBERS OF GRIEVANCE, APPEAL, AND STATE FAIR HEARING RIGHTS

We will use the member portal, the member handbook, Notice of Action letters, and the Appeal Decision Letter to advise members of their rights to file grievances and appeals. Our Member Services Representatives, in tandem with Voiance interpreters, will be trained to assist members, including those with language or special health care needs, to navigate these processes including grievances, appeals, and State Fair Hearings.

We write all member-facing grievance and appeal materials at a sixth grade reading level. Each document will note the availability of the document in other languages and other formats. We will provide interpretation services through our Member Services Department, as well as alternative forms of communication such as audiotapes, sign language, and additional reasonable accommodations. There will never be a cost to members for these services.

HELPING MEMBERS NAVIGATE THE GRIEVANCE AND APPEALS PROCESS

Both our member handbook and our member portal will include information on grievance and appeal processes and timeframes, such as:

- The definition of a grievance and an appeal

- How to file a grievance or appeal
- Communication required for grievance and appeal resolutions
- The limited time available to present evidence or allegations
- The requirement and timeframes for filing a grievance or appeal
- Timeframes for resolving grievances and appeals
- The availability of assistance during the filing process
- The toll-free numbers that the member can use to file a grievance or appeal by telephone
- Information detailing the options for self-representation or using a relative, friend, provider, legal counsel or other spokesperson as their designated representative
- Regulations that support or provide the change in federal or State law that requires action including citation of the Iowa Code and Iowa Administrative Code sections that advise members of the right to appeal
- The members right to request a State Fair Hearing if the member is not satisfied with the initial or final adverse action
- Members may request a State Fair Hearing upon completion of an Aetna Better Health appeal
- Notification of the following:
  - If a member is currently receiving services that are being reduced, denied, termed or suspended, their right to benefit continuation if the member files an appeal or a request for a State Fair Hearing within 10 calendar days from the prior denial
  - Potential member payment responsibility to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member

Educating providers and subcontractors about the grievance, appeal, and Fair Hearing process

We believe that an effective and efficient provider grievance system process begins with education. When we enter into a contract with a provider or subcontractor, we will provide detailed and specific information regarding member grievance, appeal, and State Fair Hearing procedures and timeframes. We will seek the Agency's approval of this information before disseminating this material. During our initial onsite training for new providers, we will educate providers and their staff about the available administrative tools to submit a grievance or appeal on their own behalf or with written designation on behalf of the member. During these first onsite visits, and later through scheduled and non-scheduled provider office visits, we will seek providers' feedback on administrative items to continue to improve our processes and tools.

The provider manual will describe our policy, processes, and procedures related to member and provider grievances and appeals. This information will also be available on our web portal 24/7 so that providers can access it at their convenience.

The information we provide both members and providers will include the items identified in 42 CFR 438.10 (g)(1):

- The right to file grievances and appeals
- The requirements and timeframes for filing a grievance or appeal
- The availability of assistance in the filing process
- The toll-free numbers that the member can use to file a grievance or appeal by telephone
- For a State Fair Hearing, (i) the right to a hearing, and (ii) the method for obtaining a hearing

- Citation of the Iowa Code and Iowa Administrative Code sections supporting the action in non-authorization and care review letters that advise members of the right to appeal
- The rules that govern representation at the hearing organizations

Grievances and appeals directed to the Agency

All member grievances and appeals related to eligibility will be directed to the Agency. This category of grievances and appeals includes:

- Long-term care eligibility and enrollment
- Termination of eligibility
- Effective dates of coverage
- Determination of premium, co-payment, and patient liability responsibilities

Resolving inquiries, grievances, and appeals

Aetna Better Health will leverage current Aetna Medicaid grievance system applications, processes, and procedures in the resolution of appeals, grievances, and State Fair Hearing requests. Aetna Better Health will maintain accountability for processing all member and provider grievances and appeals including those related to subcontractors. This will allow providers our members or their designated representatives, including providers who have been authorized in writing to represent the member, to contact us directly for a timely resolution of issues. Our approach to identifying and resolving grievances and appeals will expedite the resolution process and promote treating members in an equitable, effective, and appropriate manner, regardless of ethnic and cultural backgrounds. We believe that the provider and member inquiry, grievance and appeal processes are key for protecting the rights and health of our members and for improving our program operations and management.

Aetna Better Health's grievance and appeal processes will be designed to be simple and user-friendly, giving both providers and members the opportunity to voice their issues, concerns, and problems in a non-threatening manner. Our grievance system will also respond to and support all member requests for State fair hearings as defined in Exhibit A to Attachment 1 of the RFP and will conform to all applicable State and federal laws and regulations. We will provide any subsequent changes to the process to the Agency for review and approval before implementing such changes. All grievance and appeal data will be reviewed at least quarterly to identify trends and opportunities for improvement. We also generate grievance and appeal reports in a format and frequency specified by the Agency.

Grievance and Appeal staff will be located in Iowa and exclusive to our Iowa members. This will allow our members or their designated representatives, including providers who have been authorized in writing to represent the member, to contact us directly for a timely resolution of issues.

Table 8-8 demonstrates Aetna Medicaid's success in handling grievances and appeals.

Table 8-8: Aetna Medicaid's timely results for a sampling of our Medicaid plans

Member grievances and appeals	YTD actual appeals	YTD actual grievances
Missouri	100%	100%
Nebraska	100%	100%
Pennsylvania	100%	100%
Texas - Aetna Risk	100%	100%

Data review to address all requirements

We will generate grievance and appeals reports data quarterly, or more frequently as needed. We will also produce reports in a format and frequency specified by the Agency. We will maintain grievances and appeals data for seven years from date of resolution. This data will be vital to confirm that all policy and processing requirements are met and for identifying trends and opportunities for improvement, including redesigning processes, applying lessons learned to reduce the number of overturned appeals, or initiating other improvements to optimize outcomes.

Our Grievance and Appeal Committees will include cross-functional representatives from Member Services, Provider Relations, Compliance, Care Management, or other to resolve grievances and appeals, to identify trends, opportunities for improvement and implement actions. The committee will report findings a minimum of quarterly to the Service Improvement Committee (SIC) and Quality Management Oversight Committee (QMOC), summarizing the frequency and resolution of all requests.

Our committee structure will provide senior management with the authority to take corrective action to address the issues affecting individual provider and member satisfaction and to stabilize trends within the delivery system as a whole. For example, if we identify a grievance trend of providers who exceed the threshold for appointment availability or office wait time, we will take corrective action and evaluate our network for potential gaps.

Consistent evaluation of grievances and appeals trends will allow for compliance and executive staff, in conjunction with Quality Management, to improve on medical, network, operations, and management areas that require additional focus.

We fully expect to meet or exceed all processing standards for grievances and appeals. We will share our results with the Agency to confirm our performance. If we identify that any particular case is providing us challenges, we will immediately report it to the Agency.

For standard quarterly reporting, the Grievance System Manager will continue to collaborate with the Agency on what it wants in reporting. The Grievance System Manager will continue to see that reports meet Agency requirements. Our data extraction and analysis will support creating and submitting of grievance and appeals reports to the Agency at the frequency and format required.

Upon request, we will make these reports available for public inspection by redacting personally identifiable or confidential information.

GRIEVANCES AND APPEALS DEPARTMENT STAFF

The Grievances and Appeals Department will verify that individuals who make decisions on grievances and appeals have the appropriate expertise and were not involved in any previous level review or decision-making. Our Grievance and Appeal Committees will be comprised of staff with the appropriate

education, training, and expertise to make optimal and impartial member-focused decisions that support Agency and federal policy and guidelines.

The Grievances and Appeals Department will be responsible for managing the processing and resolution of all member grievance and appeal scenarios, including requests for State Fair Hearings. Responsibilities will include:

- Receiving both verbal and written grievances and appeals either directly or from internal departments and other external sources
- Documenting the intake of the grievance or appeal in the overall call-tracking system and into the Grievance and Appeals application. The application:
  - Creates an electronic file for each grievance and appeal
  - Automatically assigns a unique tracking number to each grievance and appeal
  - Electronically contains all correspondence and clinical information related to each grievance and appeal
- Overseeing the case investigation
- Assignment of the case to various internal departments as needed for investigation
- Collection of investigation results, preparation and presentation of the case to Appeal or Grievance Committee for decision or resolution
- Communicating decisions to the member, the member's designated representative, and the provider on appeal cases
- Maintaining timely process steps and resolutions
- Identifying trends and emerging issues
- Issuing reports and recommending solutions
- Creating and executing corrective action plans
- Empowering support staff to keep the process moving

Staff in other departments will also support case investigations by researching, resolving, and participating in making decisions as needed. Participants in the Grievance and Appeal Committees may represent Provider Relations, Member Services, Claims, Medical Management, Utilization Management, and others, depending on the specific case.

Grievance process and timeline

We keep the member in mind as we develop our policies, processes, procedures, and tools to make the grievance process as easy for them as possible. The substance of all member grievances will be reviewed to confirm that it meets the definition and any that are identified as related to an action will automatically be transferred to the appeal process maintaining the original received date.

We will resolve 100% of grievances within 30 calendar days of receipt, or within 3 business days of receipt for expedited grievances. We will maintain and report to the State a member grievance log, which will include the current status of all grievances.

Members and their representatives will be able to submit a grievance either in writing or by calling Member Services or other staff. The Member Services Representative—or other staff member who receives the grievance—will document the grievance in our call system and forward it to the Grievances and Appeals Department. The Grievances and Appeals Department will initiate the review.

Our goal is to resolve grievances as quickly as possible. If the grievance is reported by telephone, we will first acknowledge it verbally. We will acknowledge all reported grievances, whether submitted verbally

or in writing, with an acknowledgment letter and send it within 3 business days of receiving the grievance. We will complete the review of standard grievances within 30 calendar days of receipt.

We may extend the decision-making timeframe up to 14 calendar days, pursuant to 42 CFR 438.408(c), if the member requests an extension for any reason, or if we determine an extension is in the member's best interest. If the timeframe is extended, for any extension not requested by the member, we will give the member written notice of because the delay.

Once we render a decision, we will notify the member or designated representative of the resolution in writing within two business days of the decision and within the required 30-day timeframe. We will send the notification to the member and his or her authorized representative.

In the figures that follow, we depict the end-to-end processes that we intend to implement for grievances in Iowa: Figure 8-19 illustrates the grievance process; Figure 8-20 illustrates the tracking and trending process.

Figure 8-19: Grievance process flowchart

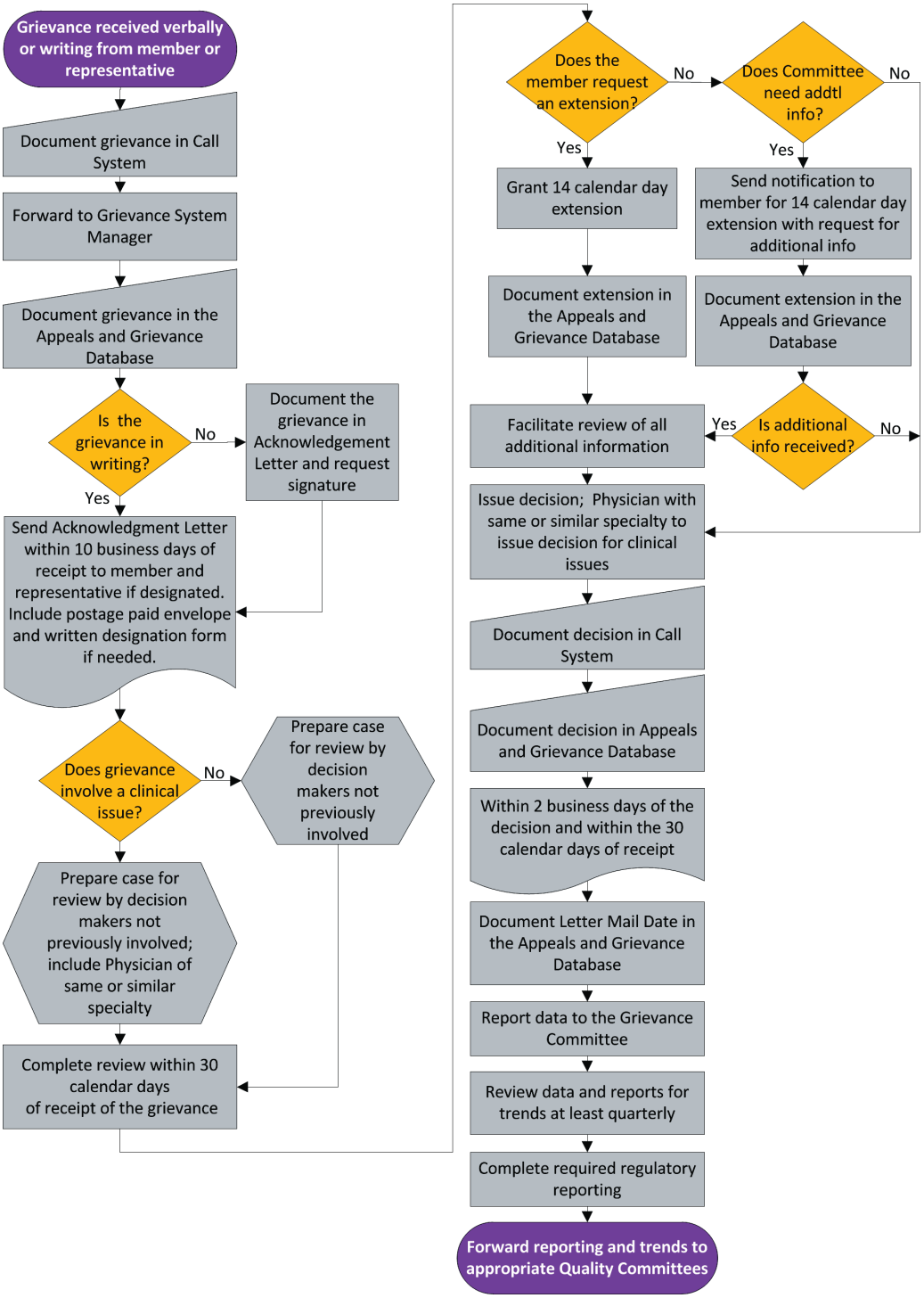
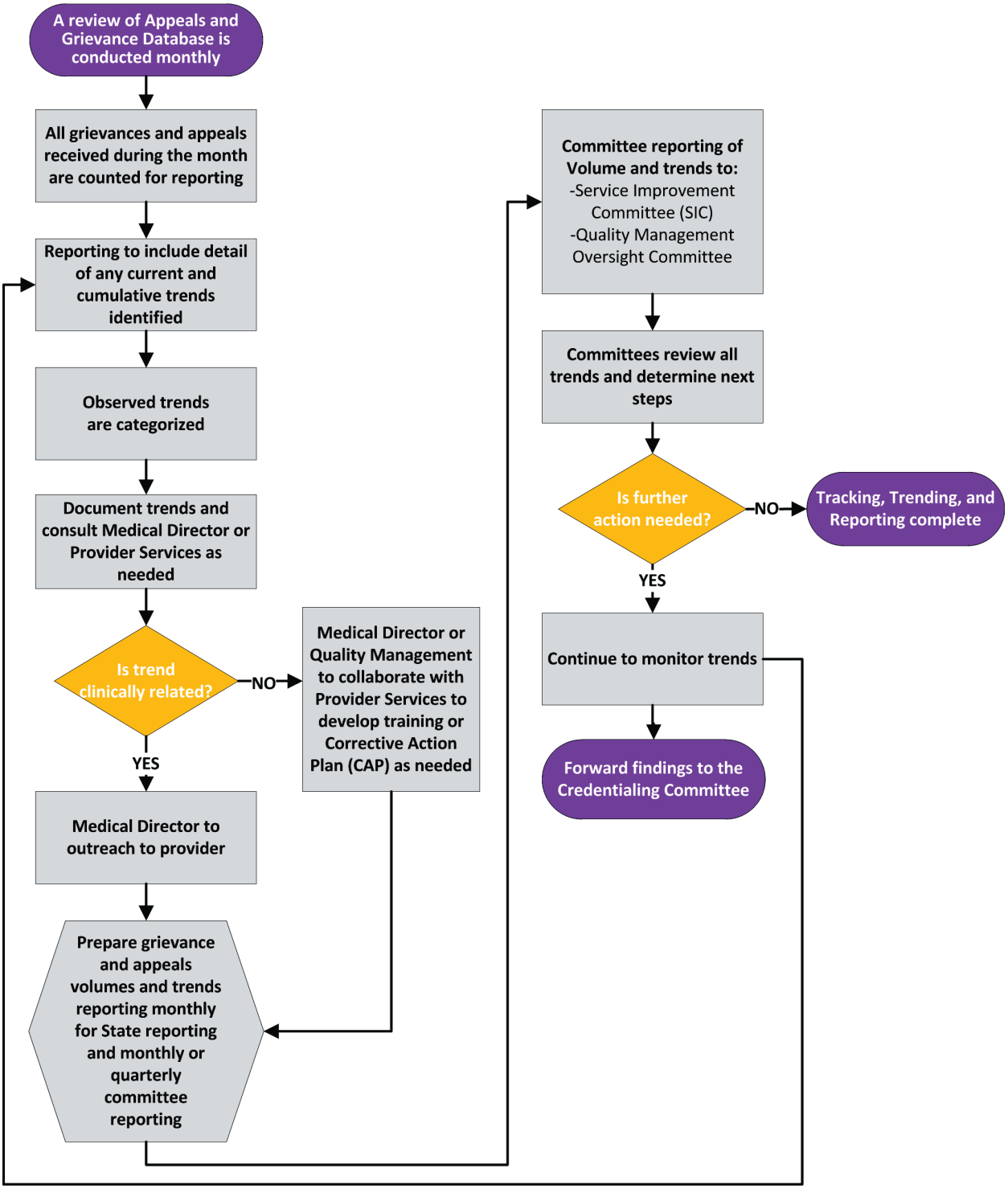


Figure 8-20: Grievance tracking and trending process



Appeals process and timeline

We understand and will follow the appeals processing timeline requirements in Attachment 1 to the RFP, Section 8.15.5.5 as detailed in the narrative that follows and outlined in Table 8-9 below.

Table 8-9: Appeals processing timeline

Member or designated representative	Timeframe to request	Timeframe to send acknowledgement letter	Extension time	Processing time	Timeframe to notify of decision	Decision letter inclusions
Appeal	Within 30 calendar days from the date of the Notice of Action letter	• Acknowledge verbally at the time of receipt Send letter within 3 business days	14 calendar days	Within 45 calendar days from receipt	Written within 2 business days of the decision and within the 45 calendar days	State Fair Hearing Rights
Expedited appeal	Within 30 calendar days from the date of the NOA letter	• Acknowledge verbally at the time of receipt Send letter within 3 business days	14 calendar days	Within 3 business from receipt	Notify verbally same day as decision within the 3 business days, and in writing within the 3 business days	State Fair Hearing Rights

Members, their designated representatives, and their providers will be able to file an appeal either in writing or verbally, by calling Member Services or any other member of the health plan.

The Notice of Action letter from the initial denial will describe the member's appeal rights and may include a request for additional clinical documentation that could assist in the resolution of their appeal. All appeals must be filed no later than 30 calendar days from the date on the Notice of Action letter. If we receive an appeal outside of the 30-day timeframe, we send the member and their representative if designated a notification of untimely filing.

We will acknowledge each appeal in writing within three business days of receipt.

The member or designated representative may present supporting evidence in person or in writing and will have the opportunity to contact us to request a copy of the member's file or clinical records that will be reviewed during the appeal review process. There will be no cost to the member for record copies.

The Grievances and Appeals Department will compile the appeal case. If we have received additional clinical information with the request, the case will be presented to the original decision-maker to be reviewed for potential reconsideration to deliver requested items or services to the member as quickly as possible.

When the original reviewer is unable to overturn their decision, we will present the case to the Appeal Committee for review. The Appeal Committee includes staff from multiple departments. The committee will include an appropriately licensed doctor or clinical peer reviewer who was not involved in the initial determination process and is not a subordinate of any person involved in the initial decision-making process.

If the deciding health care professional on Appeal Committee does not meet same or similar specialty requirements, we will send the case to an external appropriately licensed doctor or clinical peer reviewer with expertise in the same or similar specialty to review the case. All information, including any external reviewer recommendations, will be presented to the Appeal Committee for review and consideration as part of the decision making process.

The deciding health care professional will approve and sign the decision. For Expedited Appeals, please refer to the Expedited Appeals Process.

Our appeal review will include:

- The date of the appeal request, the substance of the request, including a short summary of the issues, and name of the appellant
- The initial adverse action notes and records
- Any additional clinical information and documentation submitted by the member, their representative, practitioner, or their provider
- Iowa Code and Iowa Administrative Code
- Clinical practice guidelines
- All aspects of clinical care involved
- The specialty reviewer's decision recommendation
- Upon completion the decision and the resolution

We will execute the appeals process with the utmost regard to protecting the confidentiality of PHI in compliance with our privacy policies and HIPAA requirements. We will decide all standard appeals within 45 calendar days. For both standard and expedited appeals, we may extend the decision-making timeframe by 14 calendar days if the member requests an extension for any reason, or if we determine an extension is in the member's best interest. In these unique cases, we will provide reasoning for the delay in writing to the member and to the Agency upon request.

APPEAL DECISION LETTER

We will send an appeal decision letter for pre-service and post-service appeals as quickly as the member's health condition requires within 2 business days of the decision and within the 45 calendar day processing time. We will send notification to the member, their authorized representative if designated, and the member's provider. The written notice of the appeal resolution will include:

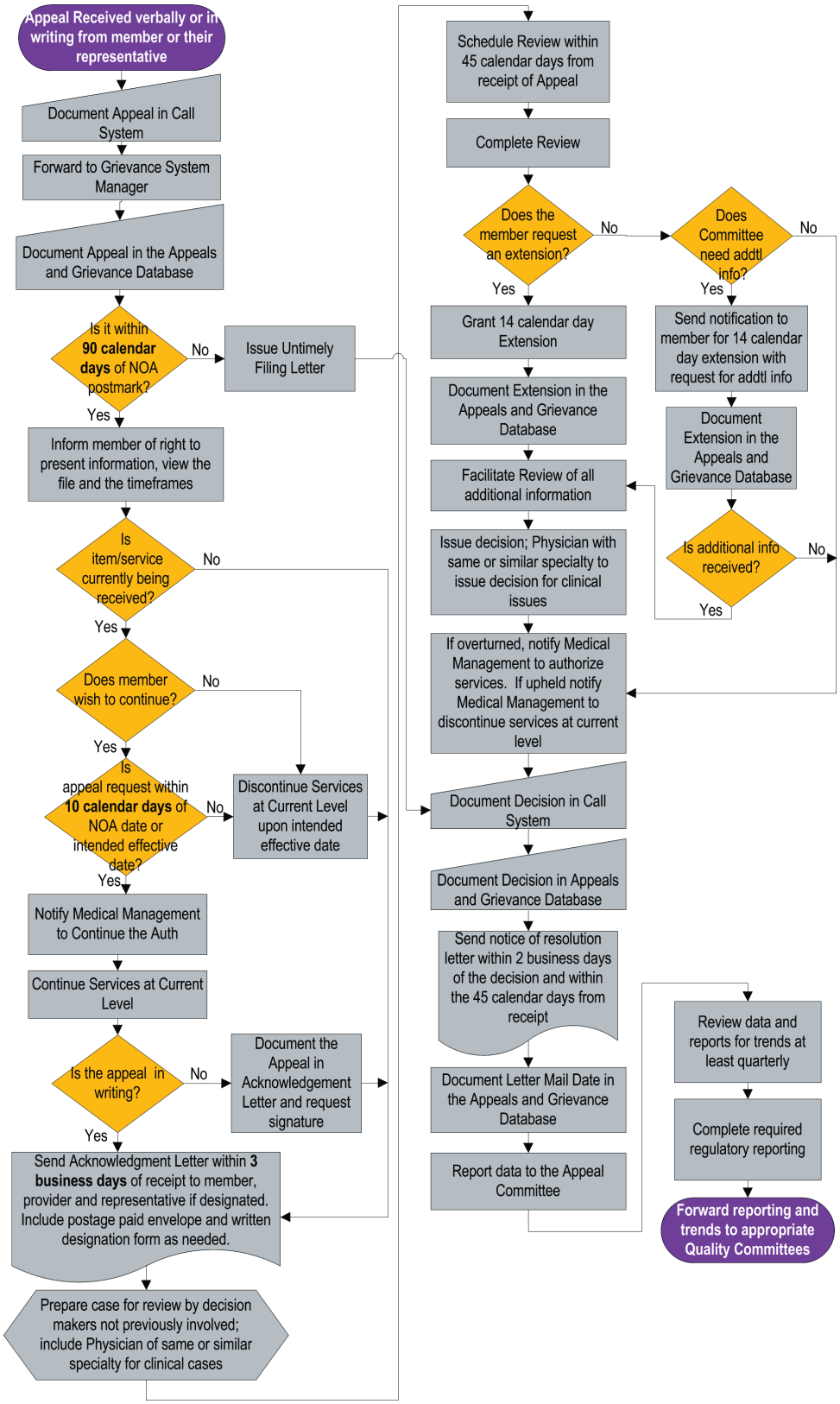
- Actions taken and reasons for actions taken
- The decision and the date it was completed
- Assistance to members on filing State Fair Hearings
- Citation of the Iowa Code and Iowa Administrative Code sections supporting the action in non-authorization and care review letters that advise members of the right to appeal
- For appeals not resolved wholly in the favor of the member:
  - The right, process, and instructions on how to request a State Fair Hearing within 90 calendar days from the Appeal Decision letter
  - When requesting a State Fair Hearing, we provide notification that the member may be held liable for the cost of those benefits if the hearing decision upholds Aetna Better Health's action
  - Directions for the member to access the Agency's Appeal and Request for Hearing form as an option for submitting a request for an appeal: https://dhssecure.dhs.State.ia.us/forms/appealrequest.htm
- The right and process to request a continuation of benefits while the hearing is pending
- A reference to the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based and notification that the member can request a copy of this information

The Grievance System Manager will forward any adverse decisions to the Agency for further review or action upon request by the Agency or our member.

STANDARD APPEALS PROCESS FLOWCHART

Figure 8-24 depicts the end-to-end processes that we propose to implement for standard appeals in Iowa.

Figure 8-21: Member appeals process



Expedited appeals process

Most appeals will follow the standard process and will be resolved within 45 calendar days of receipt. Some **pre-service** situations may require a faster decision. In those cases, we will expedite the decision-making process. This may include situations where:

- A member's life, health, or ability to attain, maintain, or regain maximum functions may be at-risk. (42 CFR 438.410 (a))
- The treating provider's opinion is that the member's condition cannot be adequately managed without urgent care or services.

These situations may include denial or partial denial of a prior authorization, reduction, suspension, or termination of a previously authorized covered service or other scenario. We will immediately initiate the appeals process upon receipt of the expedited request. We will acknowledge the request verbally at the time of receipt. If we receive a written request, we call the requester on the day of receipt to acknowledge the appeal by telephone. Neither written confirmation nor the member's written consent is required for the provider to act on the member's behalf and request an expedited appeal.

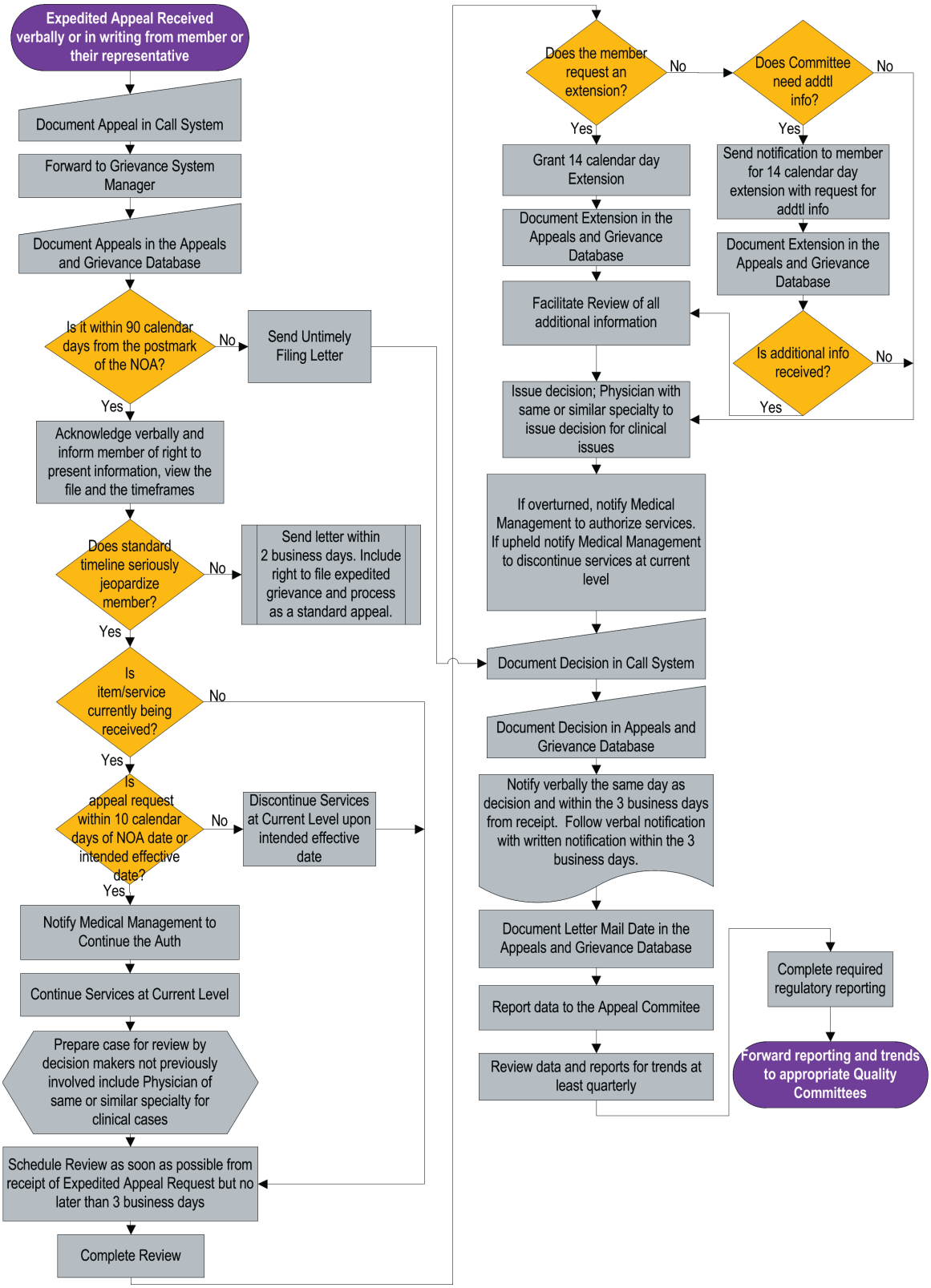
Upon receipt of a request an expedited appeal, we will review the request to verify it meets expedited criteria. If the provider is requesting an expedited appeal as their opinion is that the member's condition cannot be adequately managed without urgent care or services or the member has requested an expedited appeal and has the support of their provider it will be deemed to meet expedited criteria. If the member requests an expedited appeal on their own behalf without provider support it will be reviewed to determine if it meets the criteria in 42 CFR 438.410 (a). If the request does not meet these criteria, we will transfer request to the standard appeal process and timeframe. We will attempt to verbally notify the member immediately, and send written notification within two business days of receipt of the original request. In addition Aetna Better Health reserves the right to escalate a standard request to an expedited request if in our clinical option it would meet the criteria defined in 42 CFR 438.410 (a).

If a request meets the expedited criteria, an appropriate licensed clinical reviewer who was not involved in the initial determination and is not a subordinate of any persons involved in the initial decision, will render a decision as quickly as the member's health requires. This review will include a reviewer with the clinical expertise in the same or a similar specialty and must typically treat the medical condition or perform the procedure.

EXPEDITED APPEALS PROCESS FLOWCHART

Figure 8-22 depicts the end-to-end processes that we propose to implement for expedited appeals in Iowa.

Figure 8-22: Expedited member appeal process



CONTINUATION OF BENEFITS PENDING APPEAL

Per 42 CRR 438.420, we will continue the member's benefits during the appeal process in the following circumstances:

- The appeal was filed within the specified timeframe
- The appeal involves the termination, suspension, or reduction of a previously authorized services
- An authorized provider ordered the services.
- The original period covered by the original authorization has not expired.
- The member requests an extension of benefits
- If we continue or reinstate the member's benefits while the appeal is pending, the benefits will be continued until one of the following occurs:
  - The member withdraws the appeal.
  - Ten days pass after we mail the notice, providing the resolution of the appeal against the member unless the member, within the 10-day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached
  - A State Fair Hearing officer issues a hearing decision adverse to the member
  - The time of service limits of a previously authorized service has been met

Furthermore, a member's benefits will be continued until one of the following occurs:

- The member withdraws the request.
- Ten days pass after we have mailed the notice of an adverse decision, unless a State Fair Hearing has resolved the matter.
- The time or service limits of a previously authorized service has been met.

For additional details, please reference the Appeal, Expedited Appeal, and State Fair hearing flow charts (Figures 8-21, 8-22, and 8-23). These flow charts demonstrate the process we will implement to notify Utilization Management to continue authorization of services when a member files an appeal and requests continuation of benefits.

NOTICE OF EXPEDITED APPEAL DISPOSITION

We will make a decision no later than three business days from receipt of the request. The member will be notified, verbally, the same day as decision was made and, in writing, within the three business days. We will send notification to the member, their authorized representative if designated, and the member's provider. The written notice of the expedited appeal resolution will include the results of the appeal and the date appeal was completed.

If the appeal was not resolved wholly in favor of the member, our written notice of expedited appeal disposition will also include:

- The member's right to request State Fair Hearing, the 90-day timeframe, procedures and instructions on how to do so, and the member's right to request benefits while hearing is pending.
- Directions for the member to the Agency's *Appeal and Request for Hearing form* as an option for submitting a request for an appeal: https://dhssecure.dhs.State.ia.us/forms/appealrequest.htm
- Notice that the member may be held liable for the cost of benefits if the State Fair Hearing upholds Aetna Better Health's action.

Please also see Table 8-9, above, regarding standard and expedited appeals processing timelines.

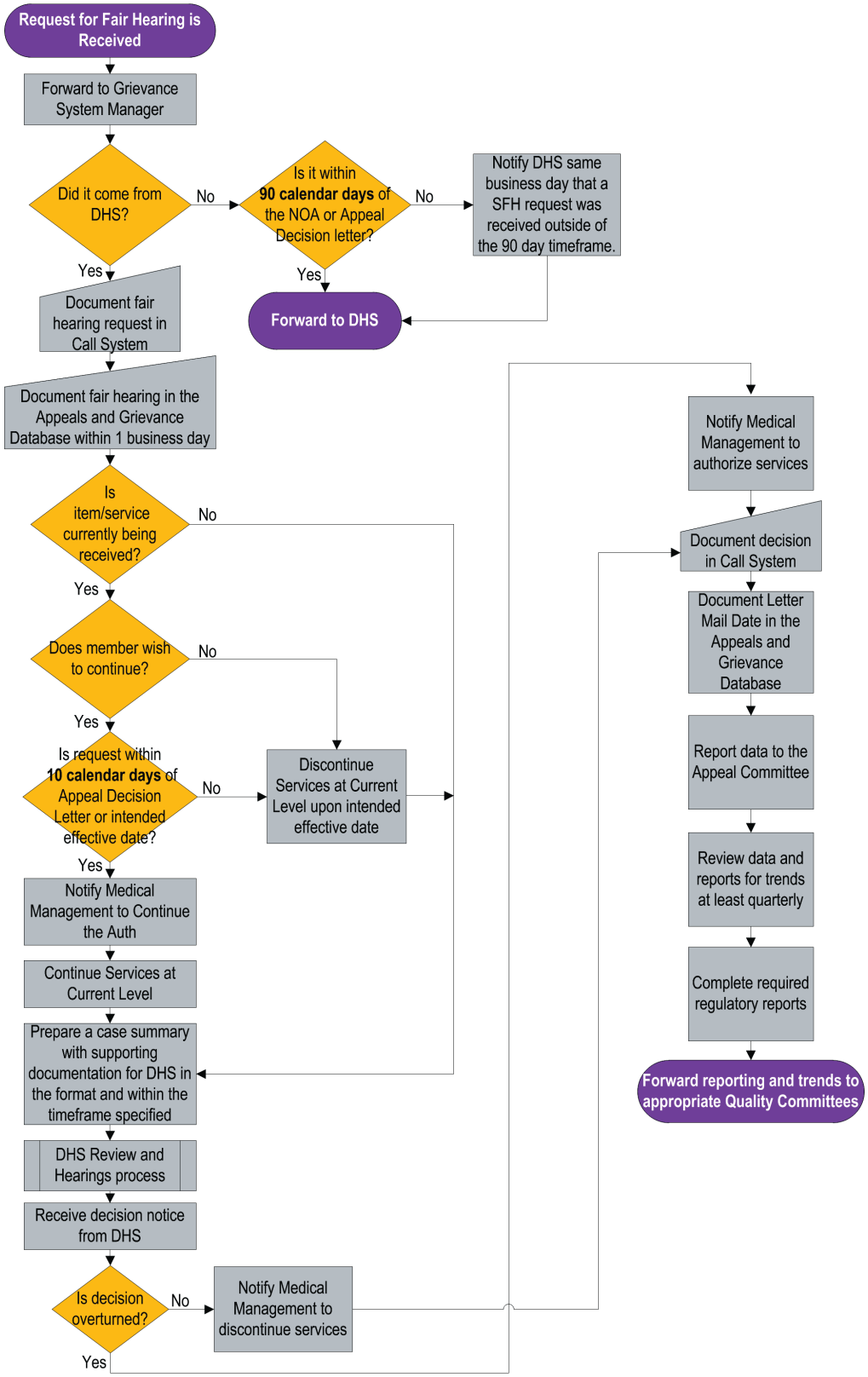
If Aetna Better Health or the State Fair Hearing Officer reverses the decision to deny authorization of services, and the member received the disputed services while the appeal was pending, Aetna Better Health will pay for those services. Standard requests will be effectuated within one business day of receipt of the State Fair Hearing Decision. Expedited requests will be effectuated the same business day of receipt of the State Fair Hearing Decision.

State Fair Hearing process

We understand, accept, and will adhere to the Agency's definition of a State Fair Hearing to mean an appeal as defined in Exhibit A to Attachment 1 of the RFP. Further, we understand that a member will be required to exhaust his or her appeal through Aetna Better Health before pursuing a State Fair Hearing. State Fair Hearings do not apply to grievances. In cases of actions required due to change in law, we will describe circumstances under which a hearing will be granted. As detailed above, we understand and will follow the State Fair Hearing requirements in Appendix 1 to the RFP, Section 8.15.6, per 42 CFR 438.408.

Figure 8-23 depicts the end-to-end process we will implement for State Fair Hearings.

Figure 8-23: State Fair Hearing process



Attachment 5 – Section 8.15, Question 2 [SOW 8.15.9]

Describe your proposed exception to Contractor policy process.

Exception to policy process

After all other options, including filing of a grievance or appeal, have been exhausted, we will offer an exception to our standard grievance and appeal process. Through this process, we will allow a member to request an item or service not otherwise covered by the Agency or Aetna Better Health to request an exception to the policy. Members or their designated representative may submit a written request for an exception to the policy as a last resort upon completion of the grievances and appeals process. This policy will include the following components:

- Information regarding policy exceptions will be included in the member handbook and on the website
- The member may make a written request for a policy exception through Aetna Better Health within 30 days of the appeal or grievance decision letter.
- Upon receipt of a request for a policy exception, Aetna Better Health will determine if the request has been submitted on time and if it includes a clinical component.
- Aetna Better Health will resolve all policy exception requests within 45 calendar days
- The exceptions to policy that we can grant will not exceed or outstrip federal or Iowa law and regulations

All requests for exception to the policy will be reported to the Grievance and Appeal Committees and reviewed for any trends and opportunities for improvement. Requests that include a clinical component will be reviewed and the decision for exception will be rendered by an appropriately licensed health professional who was not involved in any prior decision making. Non-clinical requests will be reviewed by staff who were not involved in prior decision making.

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Section 9: Care Coordination

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SECTION 9 – CARE COORDINATION

Below is a table that outlines how the Scope of Work provided in RFP Attachment 1 relates to the responses to the questions provided in RFP Attachment 5. We provide this table to reduce redundancy of responses and information and to simplify the evaluation process for the evaluators.

For requirements in Attachment 1 that do not require a detailed response, the table below indicates our intent to comply with the stated requirement in lieu of repeating the RFP question and including a will comply statement within the body of the narrative.

Attachment 1 Requirement (SOW)	Cross Reference to Attachment 5	Will Comply
9.1 General	Attachment 5 – Section 9.1.1, Question 1 Attachment 5 – Section 9.1.3, Question 1, 2	Yes
9.1.1 Initial Screening	Attachment 5 – Section 9.1.1, Question 1	Yes
9.1.1.1 Tool	Attachment 5 – Section 9.1.1, Question 1, 2	Yes
9.1.1.2 Subsequent Screenings	Attachment 5 – Section 9.1.1, Question 3	Yes
9.1.1.3 Screening Method	Attachment 5 – Section 9.1.1, Question 1, 4	Yes
9.1.2 Comprehensive Health Risk Assessment	Attachment 5 – Section 9.1.2, Question 2	Yes
9.1.2.1 Tool	Attachment 5 – Section 9.1.2, Question 3	Yes
9.1.2.2 Timeline for Completion	Attachment 5 – Section 9.1.2, Question 2	Yes
9.1.3 Care Coordination	Attachment 5 – Section 9.1.3, Question 1	Yes
9.1.4 Risk Stratification	Attachment 5 – Section 9.1.4, Question 1, 2, 3	Yes
9.1.5 Member Identification	Attachment 5 – Section 9.1.4, Question 1, 3	Yes
9.1.6 Care Plan Development	Attachment 5 – Section 9.1.6, Question 1, 2	Yes
9.1.6.1 Involved Parties	Attachment 5 – Section 9.1.6, Question 5, 6	Yes
9.1.6.2 Care Plan Requirements	Attachment 5 – Section 9.1.6, Question 1 – 9	Yes
9.1.7 Tracking and Reporting	Attachment 5 – Section 9.1.6, Question 9 Attachment 5 – Section 9.1.7, Question 2	Yes
9.1.8 Monitoring	Attachment 5 – Section 9.1.6, Question 9 Attachment 5 – Section 9.1.7, Question 1 Attachment 5 – Section 9.1.8, Question 1, 2	Yes
9.1.9 Reassessments	Attachment 5 – Section 9.1.9, Question 1 ,2	Yes

9.1 General

Please explain how you propose to execute Section 9 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Our Care Coordination Philosophy and Guiding Principles

Our values

We will effectively coordinate care for members through the building of meaningful relationships. From our first contact, we prioritize understanding the member's needs, goals, and priorities. We then use our relationships with members and their families, providers, community organizations, and other agencies to connect members to the services they need.

Aetna Better Health of Iowa Inc. (Aetna Better Health) will use Aetna Medicaid's (*Aetna Medicaid is comprised of Aetna Medicaid Administrators LLC, along with its affiliates that support the organization's Medicaid operations*) unique Integrated Care Management (ICM) program to provide effective and comprehensive care coordination for members. **ICM is member-focused rather than disease-focused.** It incorporates a member's values, needs, and priorities using a culturally-sensitive approach. We believe in member autonomy and active self-management. We capitalize on each member's strengths and supports. We help the member access a continuum of services, ranging from short-term pregnancy care management, complex care management, long-term services and supports, and end-of-life assistance. We help the member live in the most integrated and least restrictive care environment possible.

Starting with our welcome calls and initial health risk screenings, we connect members to real people when they need help. For members who need care coordination help, a well-trained Aetna Better Health Case Manager serves as the single point of contact.

Listen, Respect, and Act with Insight, Understanding, Compassion

Every member in our ICM program has a collaboratively developed Care Plan that includes mutually-agreed upon member-centered goals and actions. The Case Manager and the care team arrange for both covered and non-covered services to be coordinated for the member. The Care Plan identifies services and supports that can be provided by the member, his or her family or caregivers, community supports, community-based case managers, providers and practitioners. Through our guideline-supported care management system, we encourage all members to follow age-appropriate screening and health-maintenance guidelines as well as evidence-based care for chronic physical and behavioral illnesses. Every assessment and encounter includes member-centered attention to comorbidities and to reducing unhealthy behaviors such as tobacco use or Substance Use Disorders.

Our Care Coordination Experience

Three Decades of Caring for Those Most Vulnerable

We have been a leader in Medicaid managed care since 1986. Our care coordination services and programs improve member outcomes and reduce unnecessary costs. We currently serve nearly 3 million members in 17 states. Our nearly 30 years of experience in managing the care of the most medically vulnerable using innovative approaches allows us to achieve both successful health care results and optimal cost outcomes. We improve

performance and health outcomes through a cost-effective integrated care coordination system focused on evidence-based, high-quality health care services.

Our flexible, person-centered ICM services work for diverse Medicaid populations. We have expertise working with high need groups such as children diagnosed with developmental disabilities, members with HIV/AIDS, high-risk pregnant members, members with Substance Use Disorders disorders or serious mental illness, and other adult and child members with special health care needs. This expertise in care coordination makes a difference. Through our coordinated programs, we can address the diverse needs of various possible member cases, such as the following:

- **Autism Spectrum Disorder**: Joey is a 6-year-old boy diagnosed with ASD who was assigned to an Aetna Better Health Case Manager during initial outreach. The Case Manager coordinated with Joey's Legally Authorized Representative (LAR) to gather the assessment data necessary to create an individualized care plan. Together, they agreed that conducting the assessment in Joey's home would create the least anxiety for Joey, and keeping the assessment short and direct would help prevent him from getting frustrated. To prepare for the home visit, the Case Manager visited with Joey's PCP and his teacher to learn more about his condition, medical needs, and behavioral challenges. She then visited with Joey and his LAR at his home. This was a positive encounter for Joey and built trust with his family. Applying all of the information the Case Manager was able to gather, she referred Joey to a program for special developmental delay services and enrolled Joey in an equestrian program that helps children with autism develop socialization skills and decrease disruptive behaviors.
- **Intellectual or Developmental Disability:** Tammy is an 8-year-old girl diagnosed with Down syndrome. We linked her with a Case Manager who has experience working with children with intellectual disabilities. During development of the care plan, the Case Manager, with the approval of Tammy's PCP, successfully sought to identify a waiver program that helped Tammy get additional services she needed. The Case Manager also visited Tammy's school and obtained a copy of her Individualized Education Program (IEP) to incorporate into the care plan; this helped verify that goals were aligned between both plans and that all stakeholders were aware of the priorities. The Case Manager was also able to facilitate respite services for Tammy's caretaker once a week, helping create a more peaceful family life for Tammy and her siblings, as well as her caretaker.
- **Acute Disease – Cancer:** Holly is an adolescent diagnosed with leukemia. She was undergoing radiation and chemotherapy treatments and had no interaction with peers going through similar experiences. She began having vague symptoms of fatigue and loss of appetite that caused her to visit the Emergency Department three times in one month. Holly's mother was a single parent who had recently lost her job and her insurance. To help them, the Case Manager obtained out-of-network referrals to avoid disrupting the relationship that Holly had established with her oncologist and his office staff: promoting continuity of care. Her Case Manager also found an adolescent cancer support group in Holly's community and encouraged her to join, which afforded her peer support that helped decreased her anxiety symptoms.
- **Severe mental illness or behavioral health concerns:** John is a teen with bipolar disorder who had been hospitalized three times in two months due to active hallucinations. A drug screen performed during one of the admissions found John to be positive for marijuana use; he was then admitted to a substance use facility. The Case Manager worked with key contacts to develop a list of realistic needs and goals for him. The Case Manager worked closely with John's PCP on medical management issues and with his school to provide after-school activities based on his areas of interest. The Case

Manager made a referral to the Local Mental Health Authority following discharge and gave John's parents information on support groups.

Integrated Care Management for Medicaid

OUR UNIQUE MODEL

The Aetna Medicaid ICM program was developed in 2007 to address the problems created by fragmented systems of care. Too often, members are treated as if they have a series of individual problems. Integrated care recognizes that members are much more than their health status. Health and well-being **are the sum of the member's social, psychological, physical, and functional lives. Our approach addresses all of these domains.** We believe this improves results: members with complex illnesses and comorbid conditions, who require care across multiple clinical and social domains, are likely to be less responsive to standard care. Our data supports this.

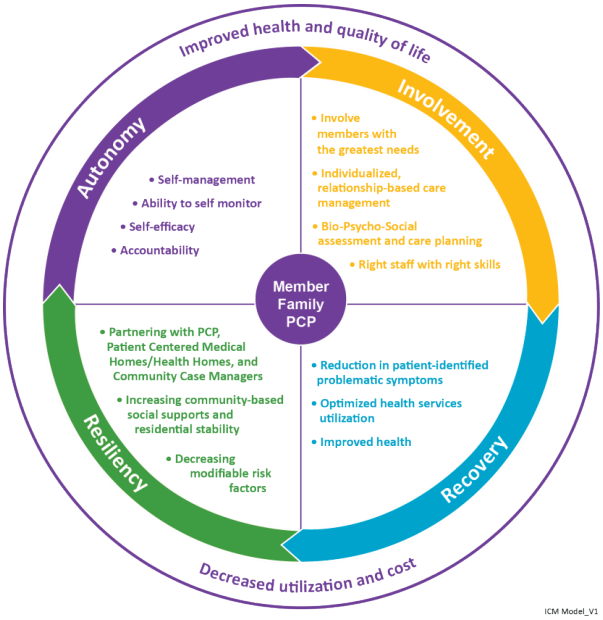
An analysis of Aetna Medicaid's claims experience shows that people who had multiple complex illnesses, and especially those with comorbid behavioral health and physical health disorders, require frequent and repeated physical health treatment. Between 70% and 90% of members with frequent inpatient admissions and emergency visits had comorbid behavioral health conditions. We realized that these members are more likely to benefit from an individualized and integrated approach to meeting their unique needs.

Pioneer in Fully Integrated Care

Aetna's ICM program is holistic, member-centered, and based on a biopsychosocial model that addresses the member's physical, behavioral, and long term services and supports (LTSS) needs. In this section we discuss our approach to integrated care for non-LTSS members; our response to Attachment 5, Section 4 addresses our approach for LTSS members**.** To identify members in need of care management, we apply our risk assessment and stratification tools to all claims and utilization data. This helps us align services according to the member's specific needs and risk level. We tailor our care coordination interventions for members with diverse combinations of needs: physical conditions, behavioral conditions, or both; members with short-term acute needs, such as a high-risk pregnancy; and members with multiple chronic conditions.

ICM is built on evidence-based practices and national care guidelines. We go beyond rudimentary compliance with evidence-based practices. Our Case Managers develop trusted relationships with members and get to know them as individuals. They are trained to speak the member in a conversational style and to use motivational interviewing to help the members identify what is important to them. Our assessments, care planning, and interventions identify the member's strengths and build on those. We support the member with tools and education at the right level and in the right language. At every phase we consult with and involve the member, the member's support system, and members of the integrated care team. Figure 9-1 shows how the ICM model supports the member in identifying the problem as well as the solutions, and develops the

Figure 9-1: Our Integrated Care Management Model



member's strengths to foster lasting behaviors that drive solutions.

While all members have access to the full spectrum of covered services, ICM identifies those members who are most vulnerable, who have complex needs, and who are at-risk for poor outcomes or those who will become high-risk and require immediate identification and intervention. ICM supports the member, family, and caregivers, reduces duplication of services, and improves outcomes.

GOALS OF ICM

The overarching goal of the integrated care management program is to optimize our member's health and ability to self-manage by connecting individuals to the right care and services. Through this goal, we aim to:

- Reduce preventable inpatient utilization
- Decrease avoidable emergency department utilization
- Increase the use of specialty care and services targeted to specific member needs
- Decrease institutionalization and help members live in the least restrictive suitable environment

INTEGRATED DELIVERY IS OUR CULTURE

Care coordination involves more than just the Case Manager; it takes a variety of staff, each with expertise in an area of health care delivery, to work together as an integrated team. At Aetna Better Health, we will promote coordinated services in each of our functional areas:

- **Member Services** staff field questions, explain benefits, and represent Aetna's values to all our members.
- Our **analytic team** transforms raw data from claims, utilization, and encounters into meaningful utilization summaries that identify issues, focus actions, and document success.
- Our **CORE predictive modeling** program helps us identify members who are at-risk.
- **Claims staff** process payments to providers and supply precise data for analysis.
- Our **technology staff** works to build, maintain, and improve our systems to support all of our clinical and administrative efforts.
- **Our provider network**, including individual providers and groups, health homes, and Integrated Health Homes, diagnose, treat, and communicate with the member. We work with our providers to expedite the delivery of services and supplies, facilitate communication, and provide comparative data to inform decision making.
- Tools such as our **Care Management Information System web portal** and **Medicity** program support the providers and communication.
- **Teladoc providers and Skype visits** will promote access in rural areas, after-hours, and for visits with specialists.
- Our **24-Hour NurseLine** will field member questions after-hours and coordinate results with the member's providers.
- **Medical Management** staff support the authorization of services and management of hospitalization, including concurrent review, discharge planning, and transitions of care. **Case Managers** interface directly with high-needs members and help to integrate services for complex members.
- The **Quality Team** monitors our care delivery processes and systems, identifies potential areas of concern, and directs interventions to improve the process or system.
- **Aetna Better Health Advisory Committees** include member representation to solicit input and feedback regarding whether our care management services meet the needs of Iowans in the

communities where they live, linking them with community resources delivered in a manner that meets community expectations.

Committed to Health Care Transformation in Iowa

Everyone within Aetna Better Health and Aetna Medicaid has a role in supporting the comprehensive care coordination needed to help the member and family, reduce redundancy, and support better outcomes. **Everything we do is member-centered.** We focus our core competencies on the member as a whole, with an integrated team approach tailored to each member's stage in life, strengths, wishes, capabilities, and circle of support.

WE PROPOSE A LOCAL, COMMUNITY-BASED PROGRAM FOR IOWA

Local Based Plan

Iowa members need services in their own communities. We propose a care coordination program that builds on the strengths of Iowa case managers and community organizations. We will offer telephonic and face-to-face services with trained case managers. Care management services may take place in home visits as well as in settings where our members seek care: Federally Qualified Health Centers (FQHCs), Community Mental Health Centers, Patient Centered Mental Homes (PCMH), Integrated Health Homes (IHH), and other community-based agencies. Case Manager training and evaluation will focus on incorporating Iowa resources, including natural supports, community organizations, and other Iowa services.

Our Iowa team has already contacted organizations that serve high needs and vulnerable populations in Iowa. These community based organizations, including faith-based organizations, will be important allies in our approach to implementing the Iowa High Quality Health Care Initiative (the Initiatives). Our early outreach included a specific focus on behavioral health and special populations including the elderly, developmentally disabled, and those with serious and persistent mental illness. Some of the stakeholder and advocacy organizations with whom we have met and intend to collaborate include:

- Area Agencies on Aging (AAAs)
- Aging and Disability Resource Centers (ADRC)
- Iowa's LifeLong Links (LLL)
- Iowa Health Care Association
- Iowa Center for Assisted Living
- National Alliance for the Mentally Ill of Iowa
- Iowa/Nebraska Primary Care Association
- LeadingAge Iowa
- Free Clinics of Iowa
- Iowa Behavioral Health Association
- Hospice and Visiting Nurses Association of Iowa

Our Value Before contract implementation, we will host job fairs and contact organizations to recruit Case Managers with Iowa-specific expertise. Our community-based Case Managers will bring knowledge of the locale, providers, and resources in the communities they serve. This understanding will help us incorporate community resources in care coordination efforts to make certain that state and community services are not duplicative. These Case Managers will also be closer to the members they serve, making it simpler to conduct face-to-face visits: we act as the local integrator of care delivery.

We have provided services in the Hawkeye State through our exchange product and understand the Iowa health care landscape. We are prepared to expand coordinated, integrated services for Iowa's Medicaid members and accomplish an effective transition for Iowa Department of Human Services (the Agency) and Iowa High Quality Health care members. By working closely with Iowa providers and community systems, we will facilitate a smooth transition for members into our plan and improve quality of care.

Aetna Medicaid Care Coordination Program Implementation in Illinois
An Aetna Better Health health plan was contracted in 2010 to serve the State of Illinois' new Integrated Care Program (ICP), serving Medicaid members ages 19 to 64 that fall into the Aged, Blind, and Disabled (ABD) category. At the time, members who were eligible for this program were being moved from a fee-for-service delivery system into managed care; enrollment in the ICP was mandatory. Aetna took a multifaceted approach to the implementation to see that members' transition of care and services went smoothly and addressed the advocates' concerns. The approach included the following:

- Creation of a solid transition-of-care process that allowed members to remain with their current providers for 90 days past the start of operations while the health plan worked to contract with their providers and authorize services tied to existing Plans of Care.
- Development of the network to encompass providers with the broad ability to serve ABD members. These efforts included conducting office site surveys to ascertain that the office was accessible.
- Targeted outreach campaign focusing on advocates and key providers, which included community meetings throughout the service area to allow them to meet our health plan leaders face to face, express their concerns, and ask questions about the ICP and the new health plan. Those who were not able to attend in person were invited to participate in webinars at no cost to them.

The implementation was successful. Advocates were especially receptive to the community meetings, noting to our leadership that the other contracted ICP health plan had not contacted them at all, let alone sponsored such community meetings.

Attachment 5 – Section 9.1, Question 1

1. **Describe proposed strategies to ensure the integration of LTSS care coordination and Contractor-developed care coordination strategies as described in Section 9.**

Our Integrated Care Management platform is key to care coordination

Pioneer in Fully Integrated Care We will make certain integrated care coordination for both LTSS

and non-LTSS members by using our **ICM program and the same ICM Information System for both populations**. Our ICM program addresses physical health, behavioral health, and LTSS care coordination services. Case managers for both programs will undergo training and evaluation on the program, supplemented by additional information needed to effectively care for the targeted population. Our specialized LTSS Case Managers, working with our ICM staff, will oversee care coordination activities for our LTSS members. Our Care Management Team works together to serve our members' needs.

Our information system allows Case Managers to enter member information, pull in data from claims and predictive modeling tools, and share member information with the member and his or her providers. We also use our data and information to help identify members needing LTSS and get them to services they need. For example, when a Case Manager identifies a member with potential for LTSS need, he or she refers the member to the LTSS team for the appropriate assessment. The referral is sent to the State if deemed appropriate or if the member wishes to be referred. We track these referrals to facilitate timely response. Detailed information about our integrated information approach is in our response to Attachment 5 - Section 9.1.7, Questions 1 and 2.

Members transitioning into LTSS care from non-LTSS ICM may remain with the same Case Manager if their current Case Manager has expertise in LTSS services. If the member's current Case Manager does not have LTSS expertise, we will transition the member by overlapping the current Case Manager and the specialized Case Manager until services are in place and the member has a comfort level with the new Case Manager. For additional details regarding LTSS care coordination services, refer to Section 4 – Long Term Services and Supports.

9.1.1 Initial Screening

Attachment 5 – Section 9.1.1, Question 1 [9.1, 9.1.1, 9.1.1.1]

1. Describe your plan for conducting initial health risk screenings.

We are collaborating with Active Health to ready our organization for the new NCQA Member Connection standards effective July 1, 2015. Their health appraisal tool meets NCQA standards, can be customized to address Iowa specific conditions or requirements, and will fully support Iowa's requirements for an initial health risk screening. This tool provides members an award winning engagement platform and offers a truly individualized experience, designed to promote personal best health. For new member risk screenings, we propose to use a member risk screen through Active Heath combined with our established Health Risk Questionnaire (HRQ) tool. This approach will allow us to meet the Agency's requirement for screening all members within 90 days of enrollment. Our initial health risk screening approach will identify members needing immediate services, identify physical, behavioral, and functional issues, and help us to channel members into the appropriate level of care coordination.

INITIAL HEALTH SCREENINGS DRIVE RAPID MEMBER ENGAGEMENT AND FLAG MEMBERS WHO NEED ADDITIONAL ASSISTANCE

INITIAL HEALTH RISK SCREEN

Members will first learn about the opportunity to complete a risk screen tool via an invitation and web link included in the Welcome Packet. Using internal data and data provided by the Agency, we will prioritize screening of any member who may be pregnant. During initial implementation of the contract, we will augment our staff to handle outreach to the initial surge of members. After the initial enrollment, our Iowa-based staff will be accountable for making timely welcome calls and follow up.

Health risk screening helps us direct members to the level of supportive services they need. Aetna Better Health will facilitate completion of initial health risk screenings for all of our Iowa High Quality Healthcare Initiative members. Members have the opportunity to complete an initial health risk screening on line via the member web portal, which is NCQA Compliant with Member Connection standards. It can also be completed by phone, by mail, or in person with assistance from an Aetna Better Health care management team member.

Flags built into the tool will alert us if the member has risk factors, on which we take action. For example, if the member indicates she is pregnant, we immediately follow up: if she is on the phone, we connect her directly to our care management staff (a warm transfer); if she is responding on our website, we will contact her to offer care coordination services. Any member who identifies risk factors in the initial screening are referred to our care management staff for a full assessment.

PERSONALIZED HEALTH RISK QUESTIONNAIRE

Another tool for member screening, which assists us in determining the member needs and risk stratification, is our Health Risk Questionnaire (HRQ). Members may be identified for a HRQ either through a welcome call or the results of the initial health risk screening tool. Using the initial health risk screening tool and our HRQ, we obtain a detailed picture of the member's physical, behavioral, social, functional, and psychological status and needs.

If we identify a member as needing care management or chronic condition management, we contact the member to perform a comprehensive health risk assessment. We also use data available to us at the time of enrollment to identify member risk factors and contact members for an HRQ assessment even if they have not completed a member risk screen. If we identify a member as at-risk, we will facilitate the completion of both the member risk screen and any HRQ questions needed to evaluate the member's specific needs.

We use three HRQs tailored for specific populations: (1) adults, (2) children, and (3) the aged, blind, and disabled population. Each HRQ includes between 14 and 17 questions written in plain language at a sixth-grade reading level. **Our care management team works directly with the member to carry out the HRQ assessment.** HRQs can be self-administered by mail but are typically administered by telephone by non-clinical staff. We will provide interpreter services when needed.

The domains addressed in the member risk screen and HRQ include:

- Member Self-Assessment
  - Physical health history
  - Behavioral health history
  - Pregnancy status
  - Overall health status
  - Clinical indicators
  - Clinical preventive services
  - Connection with a PCP
  - Access to care
  - Lifestyle: drug, alcohol, stress, exercise, healthy eating, safety
  - Pain, depression
  - Health improvement goals and motivation
- HRQ (Adult, Pediatric, Duals versions)
  - Health
  - Mental Health
  - Targeted screeners for chronic conditions and behavioral conditions

Based on member responses, we may offer the member the opportunity to participate in our care management program. The member's responses may also drive additional assessment, such as for behavioral or chronic conditions. Any member who reports a behavioral health diagnosis or being pregnant is automatically referred to care management. During these contacts, we assist any member with any immediate needs such as medication refills, identifying a PCP, or making an appointment.

Persisting Through Challenges

Stability, Competency, and Trust in the Face of Challenge

We have built a reputation for persisting through difficulties that have made others walk away. When a Medicaid managed care contractor terminated its contract on short notice with the Commonwealth of Kentucky effective Friday July 5, 2013 at 11:59 p.m., we rose to the challenge and brought 68,000 of the outgoing health plan's Medicaid members on board **immediately over a holiday weekend**. These members had no idea they had been transitioned to a new health plan overnight.

We prioritized creating a seamless transition for providers and new members, while continuing to provide the best service for our existing 200,000 members. Despite the challenges, we were able to effectively and efficiently meet the needs of our new membership.

The results of the transition were significant. We completed 1,100 case management contacts, which allowed us to:

- Identify 83 members who were high-risk obstetrical patients
- Contact all new organ transplant members and begin full medical reviews for each member
- Manage 50 behavioral health transitions-of-care and contact affected members to identify care needs

Our Member Services staff continued to experience an influx of calls from new members and achieved the highest service levels and the best average speed-to-answer rates, maintaining call-service levels at close to 99% with an average abandonment rate of less than 1%.

Attachment 5 – Section 9.1.1, Question 2 [SOW 9.1.1.1]

2. Submit a proposed initial health risk screening tool. Exhibits and attachments may be included.

Our proposed initial health risk-screening tool, offered through our collaboration with Active Health, is included with this proposal as Appendix X. Providing members the opportunity to complete the initial health risk screening and our HRQ allows us to efficiently and cost-effectively screen a large population while capturing data needed to coordinate services for the member. Aetna Better Health will also adopt the health risk screening tool required by the State of Iowa.

Attachment 5 – Section 9.1.1, Question 3 [SOW 9.1.1.2]

3. Describe the methods that you will use to determine whether changes in member health status warrant subsequent screening.

TRIGGERS FOR ADDITIONAL SCREENING

Aetna Better Health care coordination **addresses changes in member health status through the comprehensive assessment process** that we call the Care Plan Interview**.** We rely on a variety of monitoring processes to determine if a member needs additional assessment. Our methods include predictive modeling, surveillance of claims data, clinical contact and interviews, and consultation with members, providers, families, internal health plan staff, and members of the care team.

Case Managers perform **reassessments on both a scheduled and as-needed** basis when triggered by certain indicators. We reassess members in Intensive Care Management at least monthly and members in Supportive Care Management at least quarterly by reviewing the Care Plan to evaluate whether it is

meeting the member's needs. We conduct a complete reassessment at least annually for members enrolled in our ICM program. We use our suite of assessment tools to determine if the member requires a Care Plan revision or other interventions. Our response to Attachment 5 - Section 9.1.2, Question 1 discusses these tools**.** Our reassessment processes are described in our response to Attachment 5 - Section 9.1.9, Questions 1, 2, and 3.

For members who are not enrolled in ICM, we monitor for changes in their health status using multiple data sources. We monitor member-specific information through our Consolidated Outreach and Risk Evaluation (CORE) predictive modeling tool (described in detail in response to Attachment 5 - Section 9.1.3), claims surveillance, and member or provider referrals. Specific events that may alert the Case Manager to contact the member and perform an assessment include:

- Information, concerns, or issues provided by the member's family or caregiver, PCP, HH, or IHH, or other involved providers
- Enrollment transition (for example, from a non-LTSS to LTSS category)
- Identified gaps in the member's care that are related to evidence-based practice guidelines
- Discharge plan from an inpatient setting or nursing facility
- Unexpected inpatient stay or a visit to the Emergency Department (ED)
- Identification of a new chronic condition
- Pregnancy
- Catastrophic event, including transplant
- A complex acute event that might make any underlying disorder worse or make care management more complex
- A trauma-related event

If our surveillance or a referral shows that a member might need care management services, we contact them to complete a HRQ.

In addition to member-specific information, we will also conduct an **annual population assessment** to identify emerging needs in our Medicaid membership. This assessment examines demographic trends, including age, health status, and cultural characteristics to make certain our care management team is prepared to offer culturally competent, expert care management services.

Attachment 5 – Section 9.1.1, Question 4 [SOW 9.1.1.3]

4. Describe methods that you will use to maximize contacts with members to complete the initial screening requirements.

Aetna Better Health will contact members as soon as possible following enrollment to facilitate a seamless transition to the Iowa High Quality Health care program. Active Health's health appraisal tool collects member self-reported information and provides the member a health summary to share with their PCP and care team. The member has access to online tools to track their health as well as to digital coaching, personalized action plans, and a resource library. The Health Assessment is written in a friendly and engaging way and thoughtfully uses game mechanics to enhance the member experience. In addition to being available to members online it can also be administered on paper, should the member not have Internet or computer access. Member Service and Care Management staff will also be trained to support the member in completing this assessment. Member responses are used to identify members for wellness and prevention programs, integrated care management, and chronic condition management, providing further opportunities to connect members to resources that will improve and maintain their health.

In addition to the methods discussed here, we will use data available from the Agency to independently identify and contact high-risk members. **Case Managers proactively contact high-risk members** to assess and support them in our ICM program.

- **Welcome Packet** – A member's first introduction to the initial health risk screening is through our Welcome Packet, which is distributed to all members upon enrollment. We invite them to complete the initial health risk screen on our website, by mail, or by phone. We include our toll-free number in member materials and encourage members to call us if they need our help in completing the risk screen.
- **Welcome Call** – During welcome calls, we address any immediate needs of the member and offer an orientation to the plan. We also invite the member to complete the initial health risk risk screen with our assistance. This allows us to serve the member better and lets the member ask questions. If the member does not complete the risk screen within 30 days of enrollment, we will reach out again and offer to help. We make three attempts to reach the member by phone.
- [redacted] **- CONFIDENTIAL**
- **Community Outreach** – If we cannot reach a member after three attempts, we try other ways to reach him or her to encourage completion of the tool. We will work with local community organizations experienced at finding hard-to-reach people and collaborate with them to find these members. Or, we may try to contact the member by meeting them at a provider office or social services agency.
- **Assistance from Community Allies** – Throughout the process, we work with providers to obtain updated contact information for hard-to-reach members. We may enlist providers to help us reach members with the member risk screen tool. We may incentivize community organizations, PCPs, HHs, IHHs, and other providers to complete the risk screen with the member or for connecting us with the member.
- **Using Technology** – [redacted] **- CONFIDENTIAL**

9.1.2 Comprehensive Health Risk Assessment

Attachment 5 – Section 9.1.2, Question 1 [SOW 9.1.2.1]

1. **Submit a proposed validated comprehensive health risk assessment tool. Exhibits and attachments may be included.**

OUR EVIDENCE-BASED ASSESSMENT TOOL

If we identify a member as at-risk based on their answers to the HRQ question set, we refer them to our care management program. A Case Manager will use the Care Plan Interview, which is both a comprehensive clinical health risk assessment tool and a planning tool. The CPI is an interactive assessment process that evaluates risk, identifies member needs and strengths, and guides care planning. Please see Appendix K for the Health Risk Assessment Tool.

Fourteen of our health plans use the CPI tool; it will soon be implemented in three additional Aetna Better Health Plans. The CPI is derived from evidence-based clinical algorithms and meets requirements

for NCQA's Complex Care Management standards. The results drive Care Management planning, member interactions, and follow-up activities.

Our **assessment process is relationship-driven**, unlike many that are strictly transactional. An experienced Case Manager administers the tool using a conversational approach. The assessment includes the core CPI and specialized condition-specific assessments, as necessary, for chronic and behavioral conditions. We include behavioral health screens so that we can refer members for appropriate services, if indicated. Using results from the CPI, we may refer members with complex unmet physical or behavioral needs to a HH or IHH.

SPECIALIZED TOOLS AUGMENT OUR ASSESSMENTS

Our Case Managers use a **portfolio of evidence-based assessment tools.** Use of each of these tools is triggered by the information the Case Manager receives from the member during the Care Plan Interview. The member's responses help determine the intensity of services needed by the member, types of professionals to involve, and any current gaps in care. Some of the condition-specific screeners and assessments for the non-LTSS population include the following:

- **Kessler Screening Scale for Psychological Distress (K-6)** – Screens adults for mental health problems
- **UNCOPE**: Identifies adult risk of abuse and dependence for drugs and alcohol
- **Pediatric Symptom Checklist (PSC-17)** – Facilitates the recognition of cognitive, emotional, and behavioral problems in children under 19 years old
- **CRAFFT** – Behavioral Health screening tool for members under 21 years old
- **Pain Assessment** – Assess member's pain, evaluate factors impacting the pain, and the effectiveness of current pain management interventions
- **Chronic Condition Assessments** – Hypertension, Heart Failure Assessment, Depression, Diabetes Adult Asthma, Pediatric Asthma, COPD, Coronary Artery Disease (CAD), End Stage Renal Disease
- **Specialized Assessments** – Sickle Cell, Cancer, HIV
- **Infant Assessments** – Condition-specific assessment aimed at infants
- **Lead Poisoning Assessment** – Pediatric members at-risk for lead poisoning
- **Trimester Screener and Perinatal Assessment** – Screen pregnant members to identify potential risks in pregnancy.

Attachment 5 – Section 9.1.2, Question 2 [SOW 9.1.2]

2. Propose the timeframe in which all comprehensive health risk assessments will be completed after initial member enrollment.

Combined with the time to complete the initial health screening, the timeframe to complete all comprehensive health risk assessments after initial member enrollment may range from 30 to 120 days. Table 9-1 shows our timeframes and approach to steps in the care coordination process.

Table 9-1 Timelines for Aetna Better Health Care Coordination Contacts and processes

Process	Timing and Frequency
Initial Health Risk Screening (online tool)	• High-needs members prioritized for direct contact at contract implementation • A variety of written and telephonic offers to facilitate this screening within 90 days of enrollment after initial enrollment surge • High needs members contacted within five days of referral to Care Management
Health Risk Questionnaire (HRQ)	• Attempts are made within 30 days of enrollment to determine if newly enrolled members would benefit from a HRQ and possible referral to care management.

Process	Timing and Frequency
Comprehensive Assessment (Care Plan Interview) with Condition Specific Assessments	• Within 30 days of the member being identified as a candidate for care management (e.g.,after they have completed the HRQ and stratified as intensive) • Reassessment no less than annually and also when member status changes
Comprehensive Care Plan	• 30-120 days after enrollment for members after new contract implementation • After initial contract implementation, Care Plans will be in place 30 days from comprehensive assessment (Care Plan Interview) • Care plan review and update monthly for intensive ICM members and quarterly for members in supportive level of ICM
Intensive Care Management	• Face-to-face visits in home or community settings, plus telephone contact • At least monthly contact to monitor care, assess needs for changes, update Care Plan
Supportive Care Management	• Telephone visits with face-to-face visits as needed • At least quarterly contact to monitor care, assess needs for changes, update Care Plan
When there is a trigger indicating immediate need (e.g.,discharge from hospital or change in home status)	• Telephone or face-to-face visit as needed based on member need • Assessments and review of Care Plan as needed

Attachment 5 – Section 9.1.2, Question 3 [SOW 9.1.2.1]

3. Describe how the assessment process will incorporate contact with the member and his/her family, caregivers or representative, health care providers and claims history.

OUR ASSESSMENT INTEGRATES ALL AVAILABLE INFORMATION

We conduct comprehensive assessments through telephone or face-to-face contact in the member's home or a community-based setting. We follow HIPAA-compliant processes for engaging with family, providers, and others who are involved in the member's care. Members can choose to include other family members, providers, or caregivers, and we encourage them to do so.

Listen, Respect, and Act with Insight, Understanding, Compassion

We use Interdisciplinary Care Team (ICT) meetings as an important forum for involving members, families, and providers in the planning process. ICT meetings will include the member and other designees as requested by the member or required by the State. The team commonly includes the member, member's family or supports, providers, and the plan's care management staff and clinical leaders or others involved in the member's care. We also incorporate provider input through direct interface and through their input to in the Aetna Better Health web portal. Case Managers may also request telephonic contact or visit the provider office.

We capture assessment results and other member information within our Care Management Information System, where we incorporate all available information regarding the member into care planning discussions: member risk screen and HRQ results, and information from medical management, telephonic contact, medical and pharmacy claims history, and information from providers.

9.1.3 Care Coordination

Attachment 5 – Section 9.1.3, Question 1 [SOW 9.1, 9.1.3]

1. **Describe in detail your proposed care coordination program including selection criteria and proposed strategies.**

A COMPREHENSIVE, PERSON-CENTERED CARE MANAGEMENT PROGRAM IN IOWA

Our proposed program in Iowa adapts our unique ICM program to the specific needs of Iowans. Our ICM program recognizes that every person is best cared for in a holistic manner. ICM integrates every aspect of care – physical, behavioral, and functional – in a unified team and set of processes. It does so under one roof; Aetna Better Health **does not outsource program components.** Physical and behavioral health clinicians, including physicians, registered nurses and advanced practice nurses, and licensed behavioral health specialists work face-to-face and side-by-side daily to identify members who have complex needs; assess and analyze their conditions; and coordinate with providers and community resources to deliver comprehensive health care and support.

ICM uses a disciplined methodology to identify our members who have the greatest biopsychosocial complexity – the ones who need the most care and support. Through our ICM program we:

- Support members in defining their health goals, health care decisions, and care plans
- Remove or minimize the barriers that limit their ability to manage their own health and well-being
- Educate members about chronic disease self-management
- Help individuals remain in the least-restrictive, most-integrated environment based on their own preferences, needs, safety, burden of illness, and availability of family or other supports in a manner consistent with their personal and cultural values and beliefs

Our goal is to help members develop resiliency and move toward self-direction and self-management of their conditions to achieve their optimal level of health and functioning.

Assessments, care plans, stratification, and monitoring are discussed in upcoming responses. In this section we describe our model, selection criteria, and the specific programs we will use to address the priorities identified by the Agency.

INTEGRATED PHYSICAL AND BEHAVIORAL CARE COORDINATION

Pioneer in Fully Integrated Care

Aetna Better Health's approach to care coordination is to develop and maintain supportive relationships with the member to improve physical, behavioral health, and social functioning. We begin the relationship with a warm outreach to each member; maintain it through regular, supportive, and need-based interactions; and augment it by creating meaningful relationships with the member's communities. We identify members who need care coordination services both through initial and comprehensive assessments, claims data, and provider or member referrals. Members can self-refer into our care and chronic condition management programs. We can use referrals made by providers and hospitals to initiate immediate care at the point of service or to alert us to the need for ongoing care management of a member.

Our principles for ICM are:

- **Providing member-centered care management services** – Our care management is centered on the member, his or her family members, and their circle of support.
- **Identifying and employing the most effective intensity of evidence-based, plan-covered benefits and community services** – The assessment and re-assessment process supports understanding of the level of care and services required for each member and also considers the dynamic changes occurring in each member's life. We facilitate access to services, including those covered by Medicaid, non-covered services, community resources that address each member's root causes—based on the intensity and complexity of each member's needs consistent with the member's personal and cultural values, beliefs, and preferences. Member choice is paramount.
- **Engaging the member holistically** – Our Case Manager is the single point of contact, engaging the member in a collaborative working relationship. The relationship continues throughout the ICM process as the member recovers, becomes increasingly resilient, and ultimately becomes better able to manage his or her own continuing recovery and health care. Together they develop a Care Plan that addresses the member's critical physical, behavioral, and social needs. The Case Manager is the coach, facilitator, and integrator for ICM and care coordination activities.
- **Teaming with the member, family, representatives, and care providers to address all member needs** – The ICT addresses complex needs for members. This team combines core competencies in physical and behavioral health with the capacity to incorporate psychosocial wraparound services to address the most critical root causes limiting each person's health improvement. The team is led by the Case Manager and coordinates the delivery of services and supports for the member.
- **Coordinating benefits and services** – We focus on coordinating and integrating fragmented services and benefits such a pharmacy, behavioral services, and health care services into a system of care that addresses each member's individual needs within the context of that person's family and cultural community. When needed we collaborate with schools, social services, and justice systems to get members the care they need.

We support our Case Managers with an array of information and tools to help them get members into the right levels of care. Our care management program uses information to find the right people, offer members the services they need, based on the member's goals and priorities, track and monitor to determine if quality services are provided, and evaluate the member's experience with care. Our Care Management Information System integrates care authorizations, tracks appropriate and timely care, generates reports on performance, and flags opportunities for care coordination, such as admissions, ED visits, or discharges.

Other key health information system applications are described in our response to Attachment 5 - Section 9.1.7, Question 2 and in our response to Attachment 5 - Section 13 – Information Technology.

EXPERIENCED, SPECIALIZED CASE MANAGERS SUPPORT MEMBERS

Local Based Plan

Each member enrolled in ICM will be assigned a primary Case Manager. Case Managers have expertise in serving the target populations, including those specializing in behavioral health, LTSS, pediatrics, and substance use, to confirm that members receive integrated, effective, medically necessary services. We emphasize community-based, recovery-oriented, and family-inclusive services for members with behavioral health challenges.

We put our care management staff where it is needed. Some will be in Aetna Better Health offices in the state; others will work at home or on the road throughout Iowa, making it easier to reach high-risk members when and where needed. We emphasize face-to-face contact for members, when

appropriate, to facilitate communication, engagement, and action, thereby helping to improve outcomes.

Our Case Managers use motivational interviewing to support members in the Care Plan process, including identifying goals and preferences most important to them. Effective member engagement facilitates progress towards meeting goals, and promotes behavior changes that can positively influence health outcomes. The Case Manager conducts the interviews through a combination of face-to-face and telephonic contacts, depending on the member's individual needs and clinical complexity.

WE COLLABORATE WITH THE MEMBER'S INTEGRATED CARE TEAM

Care Management encourages the member to select an ICT to address the complex and varied needs of our most vulnerable members in ICM. The ICT will include the member; will be person-centered; and builds on the member's specific preferences, strengths, needs, and environmental supports. The ICT is responsible for coordination of care, services, and support that are transparent, individualized, accessible, and delivered with dignity in a linguistic and culturally competent manner.

The member's assigned case manager facilitates care management and service planning functions and initiates and leads the ICT to support the member's care and service needs. These functions include the development and implementation of a member-centered written Care Plan, assisting each member to establish access to covered and non-covered services and supports. When the member has complex medical or behavioral conditions, or when the member's situation may require additional input from a discussion with their ICT, the Case Manager will schedule a meeting to review the case with the team.

We will also work closely with care coordinators in local community providers, including FQHCs, RHCs, CMHCs, and community agencies such as the Area Agencies on Aging, Aging and Disability Resource Centers, and Centers for Independent Living and Iowa TCMs. These are critical for effective service delivery and for communicating with members to improve engagement and outcomes. We interact with providers at multiple levels, ranging from direct communication on Care Plan issues to information available through our web portal.

Integrated Case Rounds are held regularly as a forum for the care management team, utilization management staff, and Aetna Better Health clinical leaders to discuss complex members and collaborate on ways to better serve them. The clinical leaders also communicate with the provider community to assist our ICM team and to enhance care for our members. We may invite providers to attend Integrated Case Rounds in person or by telephone. Case rounds:

- Promote the use of interventions to support members receiving care in the most integrated, least restrictive, cost-effective setting to allow optimal functioning and honor the member's personal preferences
- Enhance the medical director and clinical leadership's involvement in complex cases
- Support and mentor care management and utilization management staff in using a member-centered biopsychosocial approach
- Facilitate and support members during care transitions
- Promote proactive case reviews, coordination of services, and care planning
- Provide health care and community resource linkage – especially for the member's patient-centered medical home or health home
- Identify members who may need to be referred for a higher or lower level of care management
- Improve member and provider satisfaction

Our care management staff presents a case if it meets the following criteria:

- Member is on the CORE predictive modeling target list that identifies members with risk
- High frequency of emergency department visits
- High acute care utilization
- Barriers to care are present, including social issues
- Complex or comorbid conditions
- Any case identified by clinical staff for review in support of the best clinical outcomes
- Any diagnosis, condition or situation that could potentially incur excessive cost or result in deterioration or harm to the member

Involving Community Organizations: In ICM, we involve key supports that can offer education, social services, and other types of services for the member. Table 9-2 below provides some examples of the types of organizations we will involve in the care of different types of members that shows how our services consider **all** the needs of the member, not just their health needs.

Table 9-2: Aetna Better Health Approaches for Select Populations in Iowa

Population	Specific Care Coordination Issues	Organizations We May Involve
Native American Indian	Cultural barriers, high rates of chronic disease and substance use Diabetes, alcoholism	• Tribal contacts • Community supports • Working with this population in Nebraska, AZ, MI
Children	Ensuring needed preventive services, including EPSDT	• Pediatric organizations • County health departments, WIC
Children with Special Needs	Complex home-based care needs	• Advocacy organizations • Service providers • School IEP coordinators
Foster children	Fragmented provider relationships and care records; high rate of school drop-out and justice involvement	• Social services • Advocacy organizations • Schools • Juvenile justice
Substance use	Unmet physical health needs, lack of connection with the health care system	• Peer Support • Peer outreach • Collaboration with public health organizations • Judicial system
Institutionalized members	Lack of preventive services, need for community placements	• Facility staff • Onsite care coordinators • Clinicians in facilities
Members with SMI	Unmet physical health needs, risk of inpatient care if community needs not met	• Integrated health homes • Peer support workers • Social services • Mental Health Association and other advocacy organizations • Supportive Housing Association • Division of Child Behavioral Services

Population	Specific Care Coordination Issues	Organizations We May Involve
Members with developmental disability	Need for community-based mental health services and rehabilitative services	• Social services • Advocacy organizations • Employment organizations

SELECTION CRITERIA

In Iowa, we will proactively contact the populations prioritized by the Agency to make certain they receive the care coordination services they need. Members are selected for care management based on either State eligibility category or risk level. We risk stratify and select members at highest risk for incurring inpatient care, emergency department use, complications of chronic conditions, and complications due to behavioral health issues. We assign members to care management services based on their individual needs, stratified level of risk, and categorical eligibility:

- **Members receiving LTSS**, who require treatment and services across a variety of domains of care including a broad scope of medical, LTSS and behavioral health services to make certain the best possible outcomes, including helping them live in the least restrictive settings. Please refer to our Response to Attachment 5, Section 4 for additional information.
- **Dually eligible Medicare-Medicaid members,** whose health care services will likely be funded by both programs; Medicare services may be delivered by both providers who may or may not be in our network.
- **Adults with behavioral health disorders,** who are known to have comorbid chronic medical conditions and who will receive behavioral health treatment and supports through the State and local behavioral health system
- **Children with developmental disabilities and behavioral health needs**, whose behavioral and physical health care will be administered in Integrated Health Homes
- **Children in foster care**, who often experience multiple placements which contribute to disruptions in care and lack of service continuity
- **Pregnant women,** particularly those with co-occurring conditions.

We anticipate there may be other populations targeted for care management due to certain conditions or eligibility status. We will work with the Agency to make certain these members are selected for, and participate in, our care management program. Our response to Member Identification – Section 9.1.5, Question 1 includes additional detail on our risk assessments, predictive modeling and how members are referred for care management services based on need.

A Member's Story

Leticia, a 3-year-old girl, and her family are members of Aetna Better Health's Pennsylvania health plan. Diagnosed at birth with Hypoplastic Left Heart Syndrome (HLHS), a complex and rare heart condition, she has been enrolled in our ICM program her entire life. Children with HLHS are critically ill with a combination of related heart problems. Letitia is also challenged with congenital anomalies of the great veins, necrotizing enterocolitis, septicemia, and respiratory complications.

When she was five months old, Leticia received a heart transplant and remained hospitalized until she was stable enough to be discharged home with her parents. The family's Case Manager worked with the hospital's discharge planner and Leticia's family to help them transition home. Although stable enough for discharge, Leticia had a tracheostomy and was ventilator dependent; she also required enteral feedings and 24-hour pulse oximetry. The health plan authorized private duty nursing, and the nurses provided training to her parents so they could participate in her care. With the discharge plan in place, Leticia was discharged home at 10 months of age.

Leticia's Case Manager was instrumental in the coordination of Leticia's care and helped by mediating difficult

situations and developing a trusting relationship with the family. The first month that Leticia was home was stressful and chaotic for Leticia's parents. The Case Manager was able to advocate for the family and find nurses that the family trusted. Leticia's father especially had a very difficult time throughout the transition to home: it was rewarding when he acknowledged that Leticia was happy and doing well.

The Case Manager continued to check in every two weeks for ongoing care coordination and to support the family. Once Leticia was weaned from the ventilator and her central line was removed, private duty nursing was no longer needed. Her parents managed her enteral feeding well and Leticia began receiving speech therapy to improve her swallowing difficulties. Because Leticia is medically stable, her family decided to exit the ICM program, knowing they can always call us for help.

ABOUT OUR SPECIFIC CARE COORDINATION PROGRAMS

CHRONIC CONDITION MANAGEMENT (DISEASE MANAGEMENT)

We will work to improve the health of Iowa members by offering information, coaching, and assistance on chronic disease management. The goal of our Chronic Condition Management Program is to improve our members' functional status and their ability to self-manage their chronic condition and any comorbid conditions. We help them minimize the extent to which illness interferes with their lives. The program aims to reduce longer-term premature morbidity (complications) and mortality of the condition by:

- Promoting appropriate medication adherence and compliance
- Decreasing risk of adverse outcomes, when such outcomes may be modifiable
- Encouraging reduction or elimination of behaviors such as smoking or a poor diet that may exacerbate their chronic conditions
- Identifying and facilitating treatment of problems early, before they become catastrophic or more complex
- Educating members on the signs and symptoms of their primary and comorbid conditions

We will work with members to improve quality of care and self-management capability related to their asthma, diabetes, heart failure, COPD, CAD, and depression. In addition to these programs, we will develop and implement other condition management programs required by the Agency, including programs to help manage substance use disorders, obesity, and hypertension.

Our condition-specific assessments are based on national clinical guidelines for care and self-management of specific chronic illnesses. These include: asthma (adult and pediatric modules), chronic obstructive pulmonary disease (COPD), CAD, depression, diabetes, and heart failure. We screen members for behavioral health and substance use disorders using the previously described K-6, UNCOPE, PSC-17, and CRAFFT standardized evidence-based screening tools. Our tools also screen for obesity and tobacco use.

We will incorporate the management of chronic conditions into our integrated model. The Case Manager is the single point of contact for helping the member and the care team address chronic disease and any other physical or behavioral issues. Our team notifies and collaborates with providers on Care Plan goals, appointment follow-up, and Care Plan adherence. Our care management interventions include telephonic, web-based and print education, helping the member improve adherence to medication regimens and treatment plans, and collaboration (with the member's consent) with providers and caregivers. Our **Teladoc** and **NurseLine** services are available to members to answer questions and address clinical concerns. We also help the member with appointments and follow-ups with primary and specialty providers, arrange for needed equipment, and connect the member to community agencies and support programs or groups.

Our Iowa program for chronic condition management will emphasize connecting the member to peer support groups and other community resources. This will include connecting members who have very complex health or social needs to Iowa health homes and integrated health homes as needed.

SERVICES FOR MEMBERS WITH SUBSTANCE USE CHALLENGES

We identify members with substance use issues, including alcohol, prescription and non-prescription drug use, through our initial health risk screen and care management screening processes. We also accept referrals from members or providers. We plan to use Peer Specialists to support members who we consider at-risk in their own communities. For example, our Peer Specialists may visit homeless shelters, food banks, or congregate meal programs to support individuals. We will develop relationships with specialized programs for substance use treatment in Iowa including local AA groups, IDPH clinics, and private treatment settings. Members with comorbid behavioral and substance use issues will be linked to Integrated Health Home providers.

For the 12-month period ending in July 2014, our Aetna Missouri health plan has achieved a 12% decrease in ED utilization for Asthma**.**

Using claims analysis, we will be able to identify members who are potentially abusing prescription medications. These members may be referred to ICM or the member lock-in program. Our lock-in program typically involves locking the member into one provider or provider group to obtain prescriptions for controlled substances. During the 12-month lock-in period, we will provide the member with Care Management services and reinforce the messages about appropriate medication and pharmacy usage. A full discussion of our lock-in program and protection of member rights in the program is in our response to Attachment 5 - Section 3.

OUR STRATEGIES TO REDUCE OVERUSE AND INAPPROPRIATE USE OF ED

We use several reporting, review, and referral methods to identify members who may be overusing the ED. Our data sources help us to identify members at a variety of intervals rather than waiting for single reports of utilization.

- **CORE Report** – Our monthly predictive modeling CORE report identifies members who made more than two ED visits in a rolling three months. We contact these members to identify the reasons for their ED use and will enroll them in our ICM program as needed.
- **Concurrent Review** – If the member is enrolled in ICM, we coordinate with concurrent reviewers to secure the appropriate services for members post-discharge. If the member is not enrolled in ICM, we work to enroll him or her if the concurrent review process identifies that the member is an appropriate candidate. This identification may include members who have just used the ED, members who were recently discharged from the hospital, or members who the Case Manager knows have an issue that will potentially escalate without intervention. We prioritize helping them address their issues in the appropriate care setting.
- **Referral** – We accept referrals for our ED overuse interventions from many sources, including providers, families, other agencies, organizations, or from members themselves. The referral process is important because we may not receive all of a member's ED utilization information if they have other insurance as a primary payer.
- **ICM Interventions**: We will help the member meet their health care needs outside of the ED. This may include connecting the member to social services, referring for behavioral support or crisis interventions, or helping to better manage the member's chronic conditions. We also make certain they are in contact with their assigned PCP.

- **Medication reconciliation and medication adherence**: The discharge plan contains information about the medication regimen prescribed by the discharging physician. The Case Manager follows up with the member tomake certain he or she understands how to take the medications and what potential side effects might occur. We will focus on medication optimization to increase transition successes. In addition to our standard Case Manager medication reconciliation activities, we will pilot a program that includes discharge medication review by a pharmacist and remote visits with a pharmacist to address complex regimens.

Aetna saved the State of Illinois $4.8M in the first year of our successful ED diversion programs. This amount exceeded the state's target of $3.9M.

Our primary intervention is to connect the member to an effective primary care setting and to educate the member on his or her underlying condition. Complex members, such as homeless members or those with serious mental illness, may be using the ED as a social support. We will connect these members to necessary social and behavioral services.

We also work to make certain that members are not visiting the ED because they have nowhere else to go. Aetna Better Health of Iowa will build 24/7 access with our network providers. We accomplish this through network contracts with retail clinics and telehealth providers, our 24-hour NurseLine, and increased access in health homes and integrated health homes. We will explore innovative diversion approaches for members with serious mental illness such as "Living Rooms," a program model that has been successful in other states such as Illinois and Arizona. The Living Room is a place where adults in psychiatric crisis can go instead of making an unnecessary trip to the Emergency Department. The Living Room staff includes peers as well as licensed therapists and counselors. It is an inexpensive and effective way to divert the crisis.

Our crisis response and diversion programs also help to reduce preventable institutional visits. Our strategies have been effective in other state Medicaid programs. For example, for the 12-month period ending in July 2014, **our Aetna Missouri health plan has achieved a 12% decrease in ED utilization for asthma**.

SUPPORTING EFFECTIVE DISCHARGE AND TRANSITION PLANS

Our ICM Case Managers will plan care transitions from acute care stays in hospital, psychiatric, skilled nursing, or detoxification facilities. The goal of the discharge planning process is to reduce the likelihood of complications that can lead to readmission and to promote the availability of needed services and resources to support continuity of care upon the member's return to the community. Our Case Managers also help to facilitate a safe, effective transition for members to a community setting, finding alternative care solutions where indicated, and coordinating care across multiple settings and practitioners. This decreases reliance on institutional settings while promoting the member's dignity, choice, and autonomy. Our process facilitates communication of key information to assist members through admission, discharge, and sustained reintegration in the community of their choice.

Our Case Managers work closely with the member, caregivers, the ICT, providers, and concurrent review staff to develop a dynamic member-centered discharge plan. The Discharge Plan includes member goals and information regarding medication self-management, follow-up services, and red flags that indicate the member may need to seek help from providers. Our concurrent review clinicians work with facility discharge planners regarding members who are not enrolled in ICM and refer these members to ICM for post-discharge follow-up and possible enrollment into care management. Discharge plans for these members focus on supporting the member and their family during the transition and after discharge.

The underlying philosophy is that **readmission prevention begins on the day of admission, not on the day of discharge, and should address the root causes that led to the current admission**. Our program includes the following steps:

1. Our **Inpatient Census Tool** provides us with daily documentation of members who are admitted to inpatient settings including member data, facility name, date of admission, diagnosis, length of stay, readmission risk score, and Case Manager (if applicable) for members currently receiving inpatient care. The Census tool provides a direct link to the member profile, which contains a 12-month overview of all claims and authorization data in a click and drill-down format.
2. **We contact** the acute care facility discharge planning staff to review the member's condition and begin the discussion about the services and follow-up needs post-discharge, including home health services if necessary. This discussion includes a medication evaluation and reconciliation. We may also arrange for PCP visits to the member's residence post-discharge, if indicated.
3. **Before discharge**, the Case Manager contacts the member's care and service providers, including home health service providers, and informs them of the anticipated date of discharge. If appropriate, the Case Manager will issue direction to reinstate previous Home and Community-Based Services. If necessary, the Case Manager, member, and the member's Interdisciplinary Care Team discuss any need to adjust service authorizations to meet the member's needs as noted in the revised Care Plan.
4. We also **proactively identify members who are at-risk of readmission** using our CORE application. This increases the success rate of care transitions by monitoring patient-specific risk factors. We collaborate with PCPs, PCMHs, and providers of in-home and community-based services to safely transition members to their homes.
5. Our efforts in **shaping the discharge** promote the member's remaining in the new level of care rather than returning to the same situation that resulted in the need for inpatient hospitalization or a nursing or residential facility admission.

Through our ICM program, we involve members, their caregivers and family members, and circle of support in the discharge planning and post-discharge processes. Our Case Managers facilitate member and care team understanding of the services and care processes available to them, reassessing and reviewing their plans of care with them upon discharge and post-discharge, updating needed services and goals.

Discharge plan interventions focus on the following conceptual domains:

- Use of a **member-centered personal discharge record** – An individualized discharge plan includes goals and the specific services to be provided post-discharge to stabilize the member in their home or other appropriate setting.
- **Medication reconciliation and medication adherence** – The discharge plan contains information about the medication regimen prescribed by the discharging physician. The Case Manager follows up with the member to make certain he or she understands how to take the medications and what potential side effects might occur. For Iowa, we will focus on medication optimization to increase transition successes. In addition to our standard Case Manager medication reconciliation activities, we will pilot a program that includes discharge medication review by a pharmacist when needed. We will also arrange for remote visits with a pharmacist when needed to address complex regimens for members being discharged.
- **Timely and appropriate follow-up post-discharge** – We monitor recommended treatment activities post-discharge, coordinating with the member and the member's family or other caretakers, if appropriate, and providers.

- **Knowledge about how to self-manage a health condition** – Case Managers provide educational materials and links to resources to help members and caregivers manage the health conditions effectively. Our member web portal and app provide easy access to information.
- **Enhanced Access to care** – Aetna Better Health will offer 24/7 access to NurseLine services, mental health crisis support, and Teladoc. We also make certain that health homes and integrated health homes offer extended hours for member access.

Where transitions are needed in community based care management or to obtain other community based services, we will implement processes to make the transition seamless, avoid gaps in care, and provide review of the new Care Plan so that it adequately meets member needs. We recognize that members with developmental disabilities, behavioral health disorders, or in foster care are likely to have a Targeted Case Manager when they transition to Aetna Better Health. We intend to **coordinate services with other case managers to make certain that all of our member's needs are met without duplicating efforts.** We rely on these organizations to collaborate with us to offer person-centered and comprehensive services to members. We will also work with them to increase integration of members into their community of choice to sustain the member's tenure in the community.

CATASTROPHIC CASE MANAGEMENT

We identify certain types of cases for catastrophic case management, or services provided at our intensive level of Integrated Care Management. Our Case Managers have an extensive history of managing catastrophic losses such as closed head injuries, severe burns, spinal cord injuries, and other significant traumas. We offer direction to make certain that the most appropriate medical facilities are being used. Through a coordinated effort, using telephonic and field case management, we work with the member and his or her specialized caregivers and family to develop a plan for immediate and longer-term services. Our medical experts can also offer recommendations regarding the long-term medical-financial exposure by providing assistance in establishing medical case reserves to reach the optimum outcome. We encourage our Case Managers to maintain their professional certifications demonstrating expertise in these services.

SCOPE OF CARE COORDINATION

We will take the actions needed to coordinate services holistically for the member, instead of arbitrarily limiting the scope of the Case Manager's responsibility to medical, behavioral, or LTSS services. Once we identify a member's needs and develop a collaborative Care Plan, our Case Manager assists the member to implement the plan. We refer the member to care and service resources identified in the plan, even if not specifically covered by the Iowa Medicaid benefit. This way we make certain that we help the member meet his or her needs, achieve optimal health and functioning, and work towards Care Plan goals.

Case Managers will identify social service needs of members by gathering information from the members' Initial Health Risk Screening, HRQ results, and Comprehensive Health Risk Assessment. We combine this with surveillance data from referrals and utilization management, and member- and provider-reported information. The Care Management team coordinates and integrates sometimes fragmented services to best address each member's individual needs within the context of their family, their supports, and cultural community. As needed, our Case Managers serve as the point of contact to assist members with coordinating care among specialists, community resources, long-term services and supports providers, nursing facilities, homeless shelters, and faith-based organizations who provide many critical wraparound services.

We help the member navigate the system: The Case Manager provides both simple and complex coordination interventions by:

- Obtaining any necessary release of information forms from the member, parent, or caregiver
- Consulting the online Provider Directory to identify providers who are credentialed and qualified to meet the special needs of the member (e.g., wheelchair accessible, bilingual staff, welcome members with disruptive behaviors and know how to treat them respectfully)
- Assisting with transportation arrangements if necessary and providing medical consult or referral information to the provider
- Following up to determine if the member acts on referrals to facilitate timely access to recommended services and to verify that members are satisfied with the service provided
- Contacting the member or caregiver to remind them of appointments
- Exploring any barriers to the member accessing needed services to help remove them
- Coaching the member and their caregiver, as appropriate, on the importance of keeping appointments as well as following any treatment recommendations
- Advocating for the member

We work with the community: We will build relationships in Iowa to make certain members have access to community and social services. We will contact community agencies for assistance in processing successful discharges, placements, and meeting member-specific needs. Examples of collaborative working relationships in other states we serve include:

- **Working with Area Agencies on Aging (AAA)** – Our Ohio health plan has established a relationship with an Ohio AAA to provide assistance with care management activities such as completing some face-to-face recipient assessments. Once the plan identifies a recipient and assigns them to a level of care management, our staff will work with the appropriate professional licensed AAA staff (e.g., RN or LCSW) to complete a comprehensive assessment using agreed-upon tools. This allows for input from the recipient, family members, caregivers, and providers to evaluate each recipient's medical and behavioral health conditions, LTSS, environmental, and social needs.
- **Working with Health Disability Advocates** – In our health plan in Illinois, we work closely with the Illinois Health and Disability Advocates (HDA). From the beginning of the Illinois managed care LTSS program, HDA has been onsite at our managed care organization providing state and population-specific training. This in-depth training has been instrumental in spreading awareness of State laws, regulations, and socioeconomic and cultural sensitivities needed to best serve our recipients. This relationship continues today, with regular communication and periodic training to help us monitor reception to our program, recipient and stakeholder feedback, and any challenges that need to be addressed.
- **Working with Behavioral Health Providers** – The Aetna-managed Mercy Care Plan in Arizona recognized the challenge of providing integrated behavioral health care in a service area that was new to managed care. We worked with the regional behavioral health authority, Community Partnership of Southern Arizona (CPSA), to meet the challenges and to build relationships with providers for a more comprehensive delivery system than was previously available. The collaboration has resulted in specialty Care Management by a team familiar with local resources and behavioral health needs, a stronger service network, and development of new contracts for behavioral health services in the community. The Arizona experience will help us as we develop relationships with Integrated Health Homes in Iowa.

Our Case Managers will contact Iowa's community organizations, such as the Community Action Association, the Iowa Community Foundation, and others to build effective Care Plans for members. For each unique member situation, Case Managers will develop a plan to find specific services and connect the member to those services to meet goals established in the member's Care Plan.

The result: more efficient care with fewer gaps in care. Coordination of care and service helps to increase the efficient utilization of services and avoid any gaps or duplications in care. Our Case Managers follow up on services and referrals to determine if services are received promptly. Case Managers are accountable for identifying gaps in care or service and working to remedy any gaps in treatment or services. We confirm that services are received or collaborate with the member to tackle barriers to needed services and supports.

Attachment 5 – Section 9.1.3, Question 2 [SOW 9.1]

2. Provide data on outcomes achieved in your care coordination programs operated in other states, if applicable.

CARE COORDINATION INITIATIVES IMPROVE QUALITY

Our proposed care coordination program will improve outcomes and improve cost-effectiveness of services for Iowans. Our ICM program is designed to continuously improve member health outcomes while using health care resources wisely. Care coordination outcomes are often evaluated by what does **not** happen. For example, good care coordination decreases avoidable ED and inpatient admissions, both first-time admissions and readmissions. Here we describe two health plan initiatives that demonstrate both our interventions and our care coordination outcomes:

- Reducing hospital readmission rate for members diagnosed with asthma
- Creating better outcomes for babies through prenatal care management

A 2012 data analysis and report by the consulting firm Avalere found significant results in the Aetna's Mercy Care Plan of Arizona health plan:

- On a risk-adjusted basis, Mercy Care Plan members that made higher use of preventive and ambulatory services had lower rates of inpatient utilization, ED utilization, and all-cause readmissions relative to patterns of care for dual eligibles enrolled in Original Medicare fee-for-service (FFS).
- Specifically, when compared to the total national FFS dual eligibles and adjusted to match the risk of the FFS dual eligibles, the total Mercy Care population exhibited:
  - 3% higher proportion of beneficiaries accessing preventive/ambulatory health services
  - 31% lower discharge rate (as a measure of inpatient utilization)
  - 43% lower rate of days spent in the hospital (as a measure of inpatient utilization)
  - 19% lower average length of stay (as a measure of inpatient utilization)
  - 9% lower rate of ED visits.

<u>EXAMPLE: REDUCING HOSPITAL READMISSION RATE FOR MEMBERS WITH ASTHMA</u>

Our health plan in Missouri, HCUSA, identified a trend for high utilization and costs associated with members who had a diagnosis of asthma. HCUSA implemented a Performance Improvement Project for asthma to evaluate the effectiveness of various interventions. This included face-to-face, in-home health visits to increase member awareness of the follow-up required after an asthma hospitalization. Our care management interventions:

- Offer individualized member education for triggers of asthma
- Offer case management with a home health agency for three visits
- Offer individualized education regarding asthma disease processes (acute and chronic)
- Develop asthma assessment and action plans; discuss the HCUSA asthma booklet to confirm consistency of understanding between home health and the Case Manager; support home health nurse and the asthma Case Manager as they both reinforce to the member the importance of following the health care provider's treatment recommendations
- Educate members on medication use and assessment
- Help members identify triggers inside and outside of the home
- Emphasize the importance of health care provider follow-up, including specialist referral
- Educate members on proper utilization of resources (urgent care versus ED)
- Explain the availability and use of transportation benefits
- Emphasize the importance of ongoing collaboration with the Asthma Case Manager

Before implementing an Asthma Performance Improvement Project , our Missouri affiliate experienced a baseline asthma readmission rate in calendar year 2012/2013 of 0.1132/1000 members. The program participants experienced a readmission rate of 0%. This case management intervention resulted in savings of $268,799. The pilot program had no readmissions.

In our experience, members with asthma who follow their Care Plan, use medications appropriately, and recognize triggers have improved overall health outcomes and reduced hospital admission rates. Our results confirmed this. At the start of the program, the baseline asthma readmission rate in calendar year 2012/2013 was 0.1132/1000 members. The program participants experienced a readmission rate of 0%. This case management intervention resulted in savings of $268,799. The pilot program had no readmissions.

EXAMPLE: BETTER OUTCOMES FOR BABIES

An alarming surge in the incidence of Neonatal Abstinence Syndrome (NAS) has raised attention in many state Medicaid programs. In the United States, the number of drug-affected infants (including opiates) has increased 300% since the 1980s; health care expenditures for their treatment have been estimated to be as much as $112.6 million per year. Aetna Medicaid developed a pilot program in West Virginia to curtail the adverse health impact and high cost of NAS.

We identify pregnant members using claims, state data feeds, referrals from multiple sources, and provider referrals. Substance use disorder (SUD) at any point in pregnancy will trigger high-risk care management and an individual Care Plan for the member. Our Prenatal Care Management focuses on SUD and treatment with referral of mothers to treatment facilities, if member agrees to treatment. Once the baby is born, we conduct a Neonatal Care Management assessment while the baby is still hospitalized. Our Case Manager will collaborate with the NICU staff about safe discharge plans. We create an individual Care Plan for the infant, collaborating with all medical providers, child protective services and foster parents as indicated, and the hospital social work and discharge planning staff.

Infants identified as having NAS for whom the mother was not identified during pregnancy may be admitted to the program, with referral from Concurrent Review. We began enrolling pregnant members with SUDs on April 1, 2014: **in the first three months of program operation, average utilization (NICU admissions for NAS) per thousand decreased from 2.76/1000 prior to the program implementation to 2.14/1000. We estimate the annualized savings at over $200,000.** We recognize the value in helping babies have better outcomes at birth that may have implications throughout their lives.

9.1.4 Risk Stratification

Attachment 5 – Section 9.1.4, Question 1 [SOW 9.1.5, 9.1.4]

1. Describe your proposed risk stratification methodology.

WE USE BOTH DATA-DRIVEN AND PERSON-CENTERED METHODS TO STRATIFY

Member identification and risk stratification are key components of our ICM program. While claims surveillance identifies many members who need care coordination, risk stratification **maximizes the effectiveness of ICM by identifying members with the greatest opportunity for improvement.**

We first identify members with a high medical risk by using our proprietary, **evidence-based CORE application to analyze claims data**. Predictive modeling uses analytic methods that identify people at-risk of high cost or high utilization in the future. The scores are generated from Medicaid-specific, proprietary algorithms that we have developed internally based on data from our Medicaid populations as well as our clinical and informatics expertise. Inputs to the algorithms include demographics, medical claims, and pharmacy claims data. The resulting inpatient and ED models provide member-specific scores indicating the likelihood that the member will visit the ED or experience an inpatient admission in the next 12 months. We run the model for our entire population monthly; the results are reviewed by the appropriate teams for member contact and intervention opportunities.

Members are **stratified based on their biopsychosocial complexity and the intensity of their needs.** Based on these needs, the member may become a candidate for a particular level of integrated care management. Stratification addresses the member's self-reported conditions and health care utilization (such as emergency department encounters, hospital utilization, or LTSS members with unstable conditions) or on a predictive modeling tool, which identifies members likely to be future high-utilizers based on claims and diagnostic data. These tools determine the member's potential risk level and predict that care management interventions can effectively improve the member's outcome.

CORE predictive modeling identifies **members who are candidates for intensive and supportive care** management and members who are candidates for high- and low-risk chronic condition management. Our predictive modeling shows that our highest-risk members have multiple physical health conditions: 70% to 90% had comorbid behavioral health conditions. Factors include medical, behavioral and pharmacy diagnoses and claims data. The tool predicts the likelihood of integrated care management making an impact and ranks all plan members from highest to lowest risk.

Our CORE model places members within risk groups: high-risk for an ED visit, medium or high-risk for an inpatient admission, or high-risk for high costs and poor outcomes in the next 12 months. CORE risk stratification helps to guide our outreach to members in the highest risk categories.

Of particular interest, CORE uses pharmacy claims to identify many risks related to non-adherence and other medication management issues that care coordination can influence. Approximately 40% of a member's risk assessment comes from pharmacy utilization and claims. The risks identified include:

- The complexity and number of medications in a member's drug therapy, which is a major driver of inpatient admission risk
- A member's adherence to critical maintenance medications to treat conditions like asthma, diabetes, heart failure, or a behavioral health conditions, which is a strong indicator for emergency department use risk
- Potential overlapping therapy or drug contraindications that may impact patient safety
- A member who may be using multiple pharmacies or prescribers to obtain behavioral health-related or controlled substances
- Higher member costs compared to the overall population (using the Medicaid Pharmacy risk adjustment methodology)

Figure 9-2 shows our risk groupings; we assess members for the ICM program based on the combination of risk groups to which they belong and assign them to a recommended stratification level. These stratifications are adjusted through our personalized assessments—including the Care Plan Interview—and guide assignment of the ICM service level assigned to the member.

Figure 9-2: The CORE identification and stratification process illustrated

Aetna Medicaid's Consolidated Outreach and Risk Evaluation (CORE) tool identifies members who will benefit most from our Integrated Care Management program. This tool uses acute care, pharmacy, and Long Term Services and Supports (LTSS) claims data to identify members at high-risk for adverse future health outcomes.

Identifying highest-risk members
This diagram shows three risk categories. The areas of overlap represent members at high-risk (groups 2, 4, 5, and 6) for adverse health outcomes. Group 4 represents members at the highest-risk, falling into all three risk categories.

Group #	Group name	Avg.% of members for typical TANF/CHIP/ABD health plan
1	Top 1% Gen risk ONLY	0.6%
2	Top 1% Gen risk/High-risk ED	<0.1%
3	High-risk ED ONLY	0.3%
4	High-med risk IP/Top 1% Gen risk/High-risk ED	0.2%
5	Top 1% Gen risk/High-med risk IP	0.2%
6	High-risk ED/High-med risk IP	0.6%
7	High-med risk IP ONLY	0.7%
	Percentage of members not in CORE:	97.4%

Note: Percentages may not add up to 100% due to rounding

This stratification will vary significantly by population and distribution of the population.
We have the capability to stratify risk according to each unique population.

LA TANF-CHIP_GENERAL_CORE Diagrm_V2

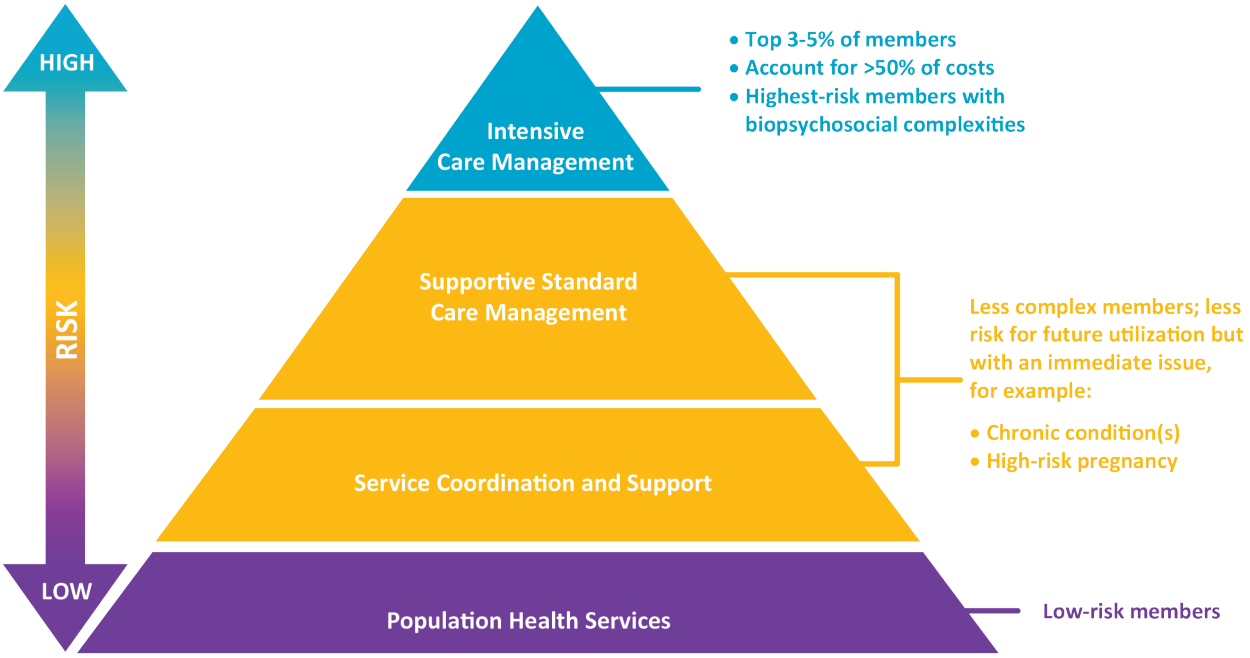
Attachment 5 – Section 9.1.4, Question 2 [SOW 9.1.4]

2. Describe your proposed risk stratification levels.

We will use three levels of stratification in our Integrated Care Management program. Figure 9-3 below shows our stratification levels and the estimated proportion of the population that typically fall within each level. With approval from the Agency, we will use these proposed risk stratification levels for initial determination of intensity and frequency of follow up care. However, we treat each member as an

individual, and tailor our care coordination activities to the member after assessment of his or her needs and priorities.

Figure 9-3: Stratification Levels



In ICM, we work to assign members to case managers who have experience in issues underlying the member's primary concerns. On completion of all assessments the member is placed into the appropriate integrated care management level of care. We propose the following risk levels for Iowa:

- **Intensive** – Members characterized by their biopsychosocial complexity will receive the full scope of integrated care management, including face-to-face visits. LTSS members in this level may be unstable or in transition. We include all members at this level of care in chronic condition management, if applicable.
- **Supportive** – Members without apparent biopsychosocial complexity, or with adequate strengths and supports to manage that complexity or who are more stable in their LTSS.
  - **Supportive Standard:** Members who have targeted medical issues or conditions who would benefit from brief, short-term interventions, such as those who are identified for high-risk condition management or a state-required condition or population. These members do not have the clinical complexity that would require intensive care management.
  - **Service Coordination and Support:** Members who need assistance with specific care or service coordination but who do not have immediate clinical needs. For example, members who need assistance finding a new PCP, identifying specialists, or referrals to community resources.
- **Population Health** – Members who require education, monitoring, or occasional outreach to review risk levels and may stratify for low risk chronic condition management interventions. LTSS members are not included in this level.

We address pregnancy at each level. High-risk pregnancies are managed in the Supportive level of service except LTSS member pregnancies, which are always classified as intensive. These members do not necessarily have many chronic conditions and they may not be using the hospital and ED frequently.

We manage them in the supportive level of care management to help the member access their provider. If the provider identifies additional health concerns, we can coordinate services for the member. If a member is pregnant and deemed to require the Intensive level of care management due to CORE or assessment scores, they will be placed at that level.

Those members who have low- or no-risk pregnancies, or those who decline a higher level, are enrolled in Population Health for quarterly screening calls. The screening calls determine if the member has new risks that may warrant a higher level of service with a clinician. We also make post-delivery calls to the member and administer a depression screening.

Attachment 5 – Section 9.1.4, Question 3 [SOW 9.1.4, 9.1.5]

3. Describe how care would be managed for members in each risk stratification level.

A case manager assesses each member within 30 days of that member's identification as a candidate for either intensive or supportive care management. The assessments guide development of the person-centered Care Plan, which determines how we manage care for a particular member. In general, components of each level of service are as follows:

ICM Service Level	Care Management Interventions
Intensive: **Complex Case Management and Chronic Condition Management (Disease Management)**	• Outreach/Enrollment • Welcome Letter • At least quarterly face-to-face visits in home or community settings, plus telephone contact • At least monthly contact to monitor care, assess needs for changes; increased frequency if clinically indicated and face-to-face if needed • PCP notification of enrollment, program education, and how to best support the patient • Encouraging members to communicate with their care and service providers • Comprehensive biopsychosocial assessment • Condition-specific assessments for physical and behavioral health • Case Formulation/Synthesis (summary of the member's story) • Member-Centered Care Plan • At least monthly care plan review and updates based on progress toward goals • Chronic condition management • Member education and coaching to self-manage their conditions and issues • Complex care coordination with both internal and the member's multi-disciplinary care team, which includes the member's identified support system • Case rounds • Integrated care team meetings as needed • Bi-annual Newsletter for primary chronic condition, Krames educational sheets • LTSS members, including those who are pregnant and stratified at high-risk, also receive assessment with the HCBS Needs Tool and a Contingency plan
Supportive: **Supportive Standard Care Management and Chronic Condition Management (Disease Management)**	• Outreach/Enrollment • Welcome Letter • Telephone visits with face-to-face visits as needed (and for LTSS) • At least quarterly contact to monitor care, assess needs for changes; additional contacts as clinically indicated • PCP notification of enrollment, program education, and how to best support their patient • Condition-specific assessments for conditions of focus • Biopsychosocial care plan which includes activities for chronic conditions and service plans (if member is LTSS eligible) • Care plan review and update at least quarterly • Chronic condition management • Coaching on the management of conditions and issues and self-care • Encouraging members to communicate with their care and service providers

ICM Service Level	Care Management Interventions
	• Education on disease process, self-management skills, and adherence to recommended testing and treatment • Care team coordination • Case rounds • Integrated care team meetings (duals & LTSS) • Bi-annual Newsletter for primary chronic condition, Krames educational sheets
Population Health: **Monitoring, follow up and education for low risk members**	• Low/No Risk pregnant members: Quarterly screening to identify risk factors • Dually enrolled Medicare-Medicaid: Annual HRQ, low risk care plans, Krames materials • Welcome letter and bi-annual newsletter for low risk chronic condition management • Special populations: monitoring/tracking per state requirements • Not applicable for LTSS

9.1.5 Member Identification

Attachment 5 – Section 9.1.5, Question 1 [SOW 9.1.5]

1. **Describe how you will identify members eligible for care coordination programs, including how the following strategies will be used:**
   a. **Predictive modeling;**
   b. **Claims review;**
   c. **Member and caregiver requests; and**
   d. **Physician referrals**

WE OFFER MANY DOORS INTO CARE MANAGEMENT

In Iowa, we will use many data sources to proactively identify members for care management and respond quickly when members are referred for care management services. In the narrative above, we discuss the process by which we open the doors into care coordination for the member: our health screening tools and predictive modeling are primary entry points. In addition, we accept referrals from multiple sources for our care coordination programs and use data from many sources to identify eligible members. On implementation of the contract with the Agency, we will seek to obtain claims and enrollment data for our pending members. This will inform our initial stratification and member identification. We will use this data to prioritize members for care coordination outreach.

Our predictive modeling and claims review processes operate concurrently and on a recurring basis. The Aetna Better Health Informatics Team produces the CORE report monthly and the risk categories feed into Our Care Management Information System monthly. Case Management Supervisors determine which to pull over for Triage and Outreach for ICM. Member and caregiver requests and physician referrals are documented in our care management system. Our Case Managers will outreach to the member in order to conduct Health Risk Questionnaire Assessments if they have not already received one. Results of the assessments determine the level of support assigned to the member.

9.1.6 Care Plan Development

Attachment 5 – Section 9.1.6, Question 1 [SOW 9.1.6, 9.1.6.2]

1. **Describe in detail how person-centered care plans will be developed for each member.**

THE MEMBER'S GOALS AND NEEDS ARE THE CENTER OF THE PLAN

Aetna Better Health of Iowa will collaborate with members to create Care Plans that **build on the member's strengths and abilities** to achieve their own level of optimum functioning. Case Managers facilitate a multidisciplinary approach to care planning by working with the member, primary care provider, specialty care and behavioral health providers, practitioners, community social workers and

providers, ancillary providers, caregivers, pharmacy providers, hospital discharge planners, and family members in the interdisciplinary care team. Case Managers will also collaborate with utilization reviewers, pharmacy, member services, and other internal resources to make certain that we consider all appropriate information for the member's Care Plan.

The Case Manager develops the Care Plan within 30 days of completing the Comprehensive Health Risk Assessment for the member. Many elements of the plan are put in place as we conduct the assessment. The Care Plan assists and encourages the members, working with their support teams, to successfully care for themselves with any supports and services needed to do so. The plan includes prioritized goals, and identifies activities and information that enhance the member's ability to make informed decisions about care, navigate the delivery system, and follow treatment plans. The Care Plan also addresses barriers identified in Case Formulation that may hinder the member's ability to reach goals or follow the Care Plan, and solutions to help reduce barriers.

Often, members have a difficult time identifying and internalizing their health care goals. Our Case Manager facilitates this process by working with the member and other participants to identify individual strengths and challenges. Using strategies such as **motivational interviewing** and **case formulation,** the Case Manager draws out the member needs, preferences, and objectives. The Case Manager reinforces prescribed health care regimens, educates the member and caregivers to improve health literacy, and encourages participation in the management of the member's health conditions and, when appropriate, LTSS. Family, caregivers, or representatives may also participate in the development of the Care Plan, with the member's consent. They are also involved in prioritizing goals that consider member, family and caregiver's needs, goals, preferences, culture, abilities and desired level of involvement in the Care Plan. We also encourage providers and other support services to participate in the care planning process.

The information gleaned from assessments and our relationship with the member is used to develop a **person-centered Care Plan that supports the member's physical and behavioral health, social and community service needs, and placement goals and preferences** if applicable.

To develop a Care Plan we:

- Conduct a biopsychosocial assessment using our Care Plan Interview tool; this includes any specialized assessments as indicated by the member's condition
- Use motivational interviewing to understand the member's goals, needs, and strengths
- Develop a Case Formulation where the member's needs, strengths, and high-priority issues are synthesized and summarized so they become the foundation of a member-centered plan
- Use motivational interviewing and the planning process to identify barriers and root causes of member issues, including inappropriate over- or under-utilization, if any
- Work with the member to specify goals that are suited to the member, honor cultural practices and beliefs, and allow him or her to experience a sense of achievement
- Document specific tasks such as completing a referral or assisting a member with access to a provider or community resource and identify who will be accountable for the task. This may include the Case Manager or others on the member's care team or circle of support
- Scheduled tasks for the Case Manager to verify the member receives care or services needed
- Identify needs for member and caregiver education on chronic condition self-management and also identify resources for meeting those needs
- If needed, discuss options for settings and levels of care, and planning any transitions

- The Care Plan includes a Transition Plan if one is needed and includes developing or verifying that there is a plan for crisis management for members with serious behavioral conditions

Each plan addresses the following elements:

- A point of contact for the member, ICT members, and Aetna Better Health staff to facilitate coordination of members' care
- Prioritized goals and actions
- Plan for seamless transitions between care settings
- Tools to assist the member and the member's family or caregiver to navigate the complex health care system
- A communication plan designating who will follow up on planned activities, and how the members of the care team will communicate
- Parking lot issues
- Emergency or crisis actions, when needed
- Contact information for the Case Manager, key caregivers, key providers and other targeted caseworkers if there are any
- Description of how we will monitor the services and activities identified in the plan

Approving the Plan: If necessary, we will review and approve any services recommended in the plan in a timely manner in accordance with our NCQA-accredited utilization management standards, which rely on evidence-based standards.

Prioritizing Issues: To avoid overwhelming the member with too many goals, tasks, and referrals, we include a **parking lot** as part of the Care Plan. We train Case Managers to work through items in the parking lot over the course of the relationship, working the issues into the conversation and plan when the opportunity presents itself.

Member Approval and Access to the Plan: Each aspect of the plan is documented in care management system. It can be revised at any time requested by the member or representative or as the member's health, service, self-management, or placement needs change. Upon completion of the Care Plan, the member agrees verbally or by signature and receives a copy. The **member and the member's family and caregivers have access to completed Care Plans** (when authorized by the member), via our web-based care management program and the Aetna Better Health app.

Sharing the Plan with PCPs and Providers: We mail a hard copy of the Care Plan to the member and primary care providers, including specialty providers serving in the PCP role, health homes, and integrated health homes. It can be mailed to others as requested. In Iowa, we expect that authorized providers will also be able to access to the member's Care Plan through our web portal. We may also use Medicity to share care planning and member-related communications with providers.

Non-Duplication: When the member has another community-based case manager, we will work to facilitate non-duplication of efforts and help the member get services from the setting of his or her choice. We encourage provider participation as Health Homes and Integrated Health Homes. We will support, supplement, or monitor care coordination activities based on the HH and IHH provider's abilities.

Attachment 5 – Section 9.1.6, Question 2 [SOW 9.1.6]

2. Describe how the care plan development process will be individualized and person-centered.

Aetna Better Health will use **motivational interviewing, an evidence-based approach, to support members in decision-making** and support them in increasing their personal responsibility for their health care and lifestyle choices. We involve the member at each step of the comprehensive assessment and the person-centered Care Plan development process. The member is at the center of the Care Plan; the Plan reflects the member's needs, preferences, and goals. Before taking action on the Plan, we have the member review and approve it. This confirms that members and their families are in agreement with specified care and treatment plans.

Our experience shows that it is critical for the member to participate in the assessment and in development and execution of the Care Plan; as such, our ICM care planning process was specifically developed to encourage member participation. We encourage and support member involvement through up-front engagement, education, and ongoing member-centered communications. During initial contact with members and families, our Case Managers provide written information and answer questions. The Case Manager asks members about their preferences for care team participants including primary and specialty care providers, other care and service providers, scheduling of services, and methods of communication. We capture the details of the initial discussions and lists of care team members in our care management information system.

In training, each Aetna Better Health Case Manager learns tools and techniques for encouraging and enhancing member participation in the assessment and care planning steps in the ICM model. The Case Manager uses **motivational strategies such as reflective listening, normalizing, and decisional balancing** to support the member or his or her representative in assessment and care planning. This facilitates active participation by the member or their representative. Our Case Managers recognize and respect personal and cultural choices and support informed decision-making by the member or their representative during the formulation of Care Plan goals.

Case Formulation is a unique feature of Aetna Better Health's care planning process and **includes a synthesis of the member's story**. Information gathered by the Case Manager in collaboration with the member, caregivers, providers, and other care team participants is synthesized to identify and understand the member's current situation and barriers to better health. This is an Aetna-proprietary process that adds value by aligning the member's perceptions with the Case Manager's understanding of the information. This allows the member to fully participate in setting Care Plan goals, actions, and interventions. Other data that may inform this synthesis are pulled in from claims, predictive modeling, and previous authorization notes. Case Formulation ensures that the Care Plan:

- Addresses the member's most important issues
- Responds to the member complexity, not to the independent clinical variables for each of the member's independent disease and condition diagnoses
- Facilitates the member's ability to self-monitor Care Plan effectiveness over time

Case Formulation identifies the member's strengths and guides development of a plan built on the goals and strengths of the member and his or her family and caregivers. The resulting case synthesis includes:

- **Primary issues and concerns** – The member and the assigned Case Manager identify one or two most concerning primary issues. These issues are used to develop current and future goals to improve the member's health outcomes; in turn, the goals drive components of the Care Plan.
- **Protective factors** – These are characteristics, variables, or conditions present in individuals or groups that enhance resiliency, increase resistance to risk, and fortify against the development of a disorder or adverse outcome. We identify positive social, cultural, and environmental conditions along with personal and social resources that promote resiliency and recovery, protect and buffer

the member, and increase the likelihood for adherence to the Care Plan and ultimately better health outcomes.

- **Barriers** – Physical, psychosocial, cultural, or economic factors can impede the ability of the member and their circle of support's ability to meet goals or achieve health outcomes.
- **Root cause** – A root cause is the underlying cause that interferes with the member's achievement of successful health outcomes. By addressing all identifiable root causes, the negative outcome can be changed or prevented. For example, a member with asthma may have frequent hospital admissions stemming from apparent non-adherence to the prescribed medication schedule at home. Deeper discussion may reveal that the root cause is the member's sharing of her medications with another family member with asthma who does not have insurance and is therefore skipping needed treatments. Unless we identify and address the root cause, the member's frequent hospitalizations will continue. By considering root causes, we are more likely to make meaningful and sustained changes in the member's health outcomes.
- **Readiness to change** – Evaluating the member's readiness to change involves developing an understanding of the member's motivations, including the desire or resistance to change. Our evaluation also considers other factors that affect the member's ability to achieve change, such as stressful life events, psychiatric status, time availability, and support. We consider the member's readiness to change in developing the Care Plan action steps, increasing member engagement for sustained improvement.

Attachment 5 – Section 9.1.6, Question 3 [SOW 9.1.6]

3. Describe how the care plan development process will incorporate findings of the initial health risk screening, comprehensive health risk assessment, medical records and other sources.

OUR CARE PLANNING TOOLS FACILITATE ACCESS TO NECESSARY INFORMATION

We will use diverse data sources to inform development of the Care Plan. When we implement the contract, we will have data from the Agency on member health status. This will help us to identify members for priority outreach and engagement. From there, we incorporate data from the initial health risk screen, the HRQ, the Care Plan Interview, claims and medical management data to inform our care.

The Case Manager creates the member's Care Plan in our Care Management Information System platform. As the Case Manager conducts the assessment, he or she enters data into the system's assessment tools. The system stores:

- Information from both the initial and comprehensive risk assessments
- Results of the Case Manager's file review of other available information on the member (such as medical records review)
- Complete member information including claims data, enrollment information, and information included in the CORE predictive model

The Case Manager considers all information available on the member while conducting assessments and creating the Care Plan. With the member's permission, the Case Manager may also contact providers to supplement information in the assessment with medical records data and provider input.

Attachment 5 – Section 9.1.6, Question 4

4. Submit a sample care plan for each proposed risk stratification level.

Appendix L includes sample care plans for our Intensive Care Management and Supportive Care Management risk stratification levels.

Attachment 5 – Section 9.1.6, Question 5 [SOW 9.1.6.1]

5. Describe how you will ensure that there is a mechanism for members, their families and/or advocates and caregivers, or others chosen by the member, to be involved in the care plan development process.

COLLABORATIVELY DEVELOPED CARE PLANS

Our ICM model emphasizes building a trusting relationship between the Case Manager and the member. Our Case Manager develops the Care Plan in collaboration with the Interdisciplinary Care Team (ICT). Case managers are trained to facilitate the process to involve people important to the member in the planning process; members select the team participants. Trust facilitates identification of the member's goals, strengths, needs, and challenges. The member is **always** the center of the Care Plan.

When the Care Plan is complete, the Case Manager reviews it with the member and provides a copy to the member in a format that the member requests. We encourage the member to post the Care Plan in a visible location so she or he can access self-management information and the Case Manager's and provider telephone numbers. The member can review the Care Plan whenever he or she wishes through the web portal, in hard copy, in direct interactions with the Case Manager, or through the Aetna Better Health app. By developing the Care Plan collaboratively and sharing it with providers, we make certain that all members of the care team are working toward the same goals and objectives.

We evaluate how we are doing to involve members:

- **Audits:** We audit Care Plans to make certain they reflect our standards for member-centered, holistic, integrated care and evaluate the effectiveness of both member and caregiver involvement through regular Care Plan reviews.
- **Member Feedback:** Our Aetna Better Health plans conduct satisfaction surveys with members who participate in the ICM program. Results show they are satisfied. For example, survey results for our Delaware plan surveyed members enrolled in ICM from January through August 2014. Members were 94% positive, either agreeing or strongly agreeing that they are satisfied.

Attachment 5 – Section 9.1.6, Question 6 [SOW 9.1.6.1]

6. Describe how you will identify other caseworkers to be included in the care plan process and how services will be coordinated to avoid duplication and/or fragmentation of services.

COLLABORATING WITH COMMUNITY-BASED CASEWORKERS

In Iowa, we will **proactively contact other care managers and caseworkers** when they are involved in the care of one of our Aetna Better Health members. We know it is likely that members in particular circumstances will have other care plans and other caseworkers. Such circumstances include members who have serious mental illness, foster children, and members who are in nursing homes, health homes, integrated health homes, or ACOs. We will identify these caseworkers by using information in our data systems, by asking the member, and through the ICT planning process. Our ICT will collaborate to specify exactly which party will do each Care Plan intervention and document the decisions in the Care Plan to prevent or avoid any duplication of efforts.

Regardless of which other health care professions, advocates, and caregivers are providing services to the member, **we are accountable for integrating information in the Care Plan**. We will incorporate information from these sources and identify accountability for services. If necessary we will develop agreements with other caseworkers and case managers for members who are accessing multiple

services concurrently or consecutively. Our Care Management Information System and web portal allows integration, tracking and access for all care team participants approved by the member.

We encourage the involvement of other organizations and individuals who can assist the member. We help the member select members of the ICT based on his or her needs. We include the member, the member's family and other caregivers, PCP, Health Home or Integrated Health Home, and others who are in the member's circle of support, as approved by the member. For example, the Aetna Case Manager might ask community caseworkers including those from child protective services, juvenile justice, or HIV programs to participate in the ICT. We encourage the member to share information about their providers with his/ her Case Manager and to discuss their Care Plan with the providers.

Attachment 5 – Section 9.1.6, Question 7 [SOW 9.1.6.2]

7. Indicate how you will ensure that clinical information and the care plan is shared with the member's PCP (if applicable) or other significant providers.

KEEPING PROVIDERS INVOLVED AND INFORMED

We propose our Integrated Care Team approach to share clinical information. Collaboration with the member's PCP, Health Home, Integrated Health Home, or other case managers is critical to achieving positive member health outcomes. Our Case Managers are accountable for updating the member's PCP or health home on the status of the member's Care Plan and any changes in the member's condition. PCPs (including specialists when they are serving in a PCP role) are invited to all discussions regarding the member's condition. Each time the Care Plan is modified, the Case Manager generates a summary letter that is mailed to the PCP.

Authorized providers, including PCPs, Health Homes, and Integrated Health Homes can **access Care Plan information through our web portal**. For providers who do not use the website, or when our Case Managers need to interact directly, we use a variety of communication methods, including the telephone, fax, in-person contact, and e-mail access through our provider portal. The Case Manager uses these methods to collaborate with the member's PCP, Health Home, or Integrated Health Home, specialty providers, and other individuals and organizations involved with the member's care, especially when there is a need to enhance or otherwise change services that the member is receiving.

While we promote collaborative approaches, **we respect the member's right to privacy**. A member's Protected Health Information (PHI) is private and confidential. We have rigorous policies and procedures to protect PHI against unlawful use and disclosure. Our care management system identifies HIPAA events where Care Management staff document their discussions about health information privacy with the member or member's representative. Members or their representatives can request a Privacy Request form by mail, e-mail, or on our website. Our Compliance Officer reviews all submitted Privacy Request forms for validity and completeness as well as compliance with all State laws for access to PHI. If someone other than the member signs the form, we must receive and validate documentation confirming that person's legal relationship to the member. We save these documents in a confidential and secure location for business review by our staff who have a business need to review (Care Management, Member Services, Utilization Management, Compliance). We also use our care management information system to document the name of any person whom the member has designated as allowed to have access to PHI; we regularly review this authorization with the member.

Attachment 5 – Section 9.1.6, Question 8 [SOW 9.1.6.2]

8. Describe how cultural considerations of the member would be accounted for in the care planning process and how the process will be conducted in plain language and accessible to members with disabilities or limited English proficiency.

PERSON-CENTERED CARE ALIGNS WITH LANGUAGE AND CULTURE

Our Value

Aetna Medicaid's efforts to improve the simplicity and clarity of communication have been recognized by the Center for Plain Language, which gave Aetna the top honor for their Plain Language Award for two years in a row (2010 and 2011).

Our goal is to address specific cultural and language needs that might challenge a member's ability to access care or understand healthy practices that lead to optimum health outcomes. Cultural competency goes well beyond ensuring availability of a language interpreter or translating printed materials into languages other than English. There are questions in our assessments to elicit cultural beliefs so that the case manager can begin to understand how these are impacting the member's health and appropriately coordinate the care and services that will meet the member's cultural needs. Cultural competency is a part of all care management training and an integral part of the mentoring of integrated care management staff by their managers and clinical leaders.

Aetna Medicaid health plans have adopted the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) developed and promoted by the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH). We are committed to following the Blueprint for Advancing and Sustaining CLAS Policy and Practice (Blueprint) by the HHS-OMH. Our methods to make certain that care planning is in plain language, accessible, and culturally relevant include:

- Training all staff members on the CLAS standards, information on the culture of communities they service, and strategies for delivering effectively culturally competent services
- Developing Aetna Medicaid standards for creating materials that are consistent with and support the national CLAS standards
- Translating our materials into any written language upon member request so that the member will have the information needed to use their health care benefits effectively
- Providing member-targeted materials that are written at the sixth-grade reading level
- Offering ADA-compliant and 508-compliant materials. We also provide appropriate access to member meetings for those members who have hearing or visual disabilities or mobility disabilities. Our Case Managers will meet with the member face-to-face in the setting of the member's choice if needed to accommodate access concerns.

In Iowa, we will offer all of these features and make any adaptations needed to communicate effectively with members in the State. We will tailor our words, the tone of our messages, and any graphic representations to meet the needs, preferences, and expectations of our Iowa members. We will make certain we meet linguistic needs of members by working with resources such as Voiance Language Services, which offers telephonic translation in more than 200 languages.

Attachment 5 – Section 9.1.6, Question 9 [SOW 9.1.6.2, 9.1.7, 9.1.8]

9. Describe how the proposed care plan process will include a system to monitor whether the member is receiving the recommended care.

HOW WE MONITOR CARE PLANS

To make certain that members are receiving the care recommended by the Care Plan, we will use our programs to identify and close gaps in care. Our approaches combine proactive care planning, information technology, engagement with providers, and proactive quality monitoring.

Anticipating and preventing gaps in care. We work to prevent gaps in care by identifying high-risk transitions and coordinating with providers. Examples of case management communication, coordination, and support strategies we use to prevent gaps include:

- Obtaining and sharing pertinent medical records with the PCP, PCMH, Health Home (HH) or Integrated Health Home (IHH), then following up regarding these records to coordinate changes in a member's Care Plan
- Informing the PCP, HH, or IHH of the member's most recent pharmacy fill history, if available
- Collaborating with the PCP, HH, or IHH to meet the member's needs and avoid gaps in care
- Supporting the PCP, HH, or IHH as they implement electronic medical records
- Facilitating follow-up appointments with PCP, HH, or IHH following an ED episode or inpatient admission

We also systematically monitor for gaps in care using the following methods:

- **HEDIS Gaps in Care** – Our business application system identifies members who have gaps in recommended HEDIS services and alerts case managers to follow up with the members on obtaining those clinical screenings and compliance with clinical practice guidelines.
- **Integrated Case Rounds** – We hold integrated case rounds at least twice monthly; these provide a forum for the care management team, utilization management staff, and clinical leaders to discuss complex members and collaborate on ways to better assist them. Our clinical leaders also communicate with providers when needed to assist our ICM team and to enhance care for our members. We may invite providers to attend Integrated Case Rounds in person or by phone.
- **Tracking Care and Services to Identify Gaps** – Our Care Management Information System provides a view to all authorized services to monitor for gaps in care, helping to improve quality and enhance operational efficiency.
- **Monitoring Service Delivery** – We track service delivery by in-home providers such as home health aides and personal care attendants using the Electronic Visit Verification System. Through our integrated claims system we will post results from EVV to identify service gaps, promote quality of service delivery, and help prevent fraud, waste, and abuse. We are currently researching options and may either elect to implement an EVV and offer it to service providers, allow service providers to implement an EVV, or some combination of both. There are several considerations in this decision including EVV systems currently in use, costs of implementation, and ease of data integration, among others. If needed we may invoke the member's contingency plan or to provide direct care providers when service gaps occur. We track and trend any gaps in LTSS services and make certain that the member's contingency plan is acted upon based on member's wishes at the time the service gap occurs.
- **Care Plan Review and Member Report** – We review Care Plan regularly with the member. At each review we ask the member if services are meeting his or her needs. If they are not, or if we observe additional needs, we will modify the Care Plans or correct any omissions.

ADDRESSING GAPS IN CARE

Our primary strategy for reducing gaps in care is to work closely with the member's PCP, HH, or IHH to make providers aware of and remediate gaps in care. Clinical gaps are the responsibility of the provider. We help the provider identify these gaps by monitoring claims and assessing the member. We alert the providers so that they can address non-urgent issues at the member's next visit.

For service or non-clinical gaps, our Case Managers work through the Care Plan process to develop solutions. Members can contact their Case Managers when needed. When the Case Manager is not available, our Member Services staff (available year-round, 24/7) and our 24-Hour Nurse Line for after-hours calls are available to members. Member Services staff are trained to identify urgent issues such as an impending behavioral crisis or no-show of a critical support service. Staff members can either activate a back-up plan for the member or can connect the member with one of our clinical Case Managers.

We strive to prevent service gaps by working with the member to develop an emergency or back up plan. We identify situations that might trigger a problem, and work with the member and his or her caregivers to develop a plan. For example, we might provide telephone numbers of alternative providers or the location of services where the member can access care on an urgent basis.

9.1.7 Tracking and Reporting

Attachment 5 – Section 9.1.7, Question 1 [SOW 9.1.8]

1. **Describe how you propose to track and report on care coordination programs and share care coordination information with the member, authorized representative and treatment providers.**

OUR MONITORING PROCESS AND QUALITY PROGRAM

In our Iowa program, we propose to use our Integrated Care Management Information System and processes for member-centered integrated care management to track information and share it with members of the integrated care team.

Notifications for Care and Service Monitoring: We use our Care Management Information System to monitor for care gaps, changes in member status, and adherence to the Care Plan. This system integrates information from the initial health risk screenings, HRQs, comprehensive risk assessment, the Care Plan, any changes in member health status or outcomes, and other information. We always notify the member's PCP or other lead providers that the member has been enrolled in our care management program and encourage them to collaborate in planning and implementing care. We also encourage members to communicate with their providers, and offer coaching to assist them.

Care Plan Review: We monitor member Care Plans regularly to make certain that the plan is regularly updated with the member's progress and any concerns. The Case Manager updates the Care Plan any time a member's needs, conditions, or placement changes. Each Care Plan is reviewed at least monthly for members in intensive case management and at least quarterly for members in supportive case management. We reassess members at least annually when they are enrolled in ICM.

Our Methods to Share Information: We have previously discussed several of our tools for sharing care coordination information with important stakeholders. These tools create a circle of support to help the member, family, and caregivers with needed tasks and ready access to care coordination information. We use various methods to communicate with the member and family, behavioral health providers, PCPs, health home and integrated health home providers, and specialists:

- Telephonic and face-to-face visits in homes, provider offices, and community settings

- Mail, fax, texts, and e-mail when we have the necessary contact information
- Interdisciplinary Care Team meetings, which involve members, providers, and Case Managers
- Secure web portal for members and providers
- Medicity communications platform enables two-way exchange with providers who have the appropriate technology and connectivity
- Aetna Better Health app, which provides secure messaging between members and our Case Management team

Standards for Reporting: We will develop Iowa-specific policies and procedures for reporting of urgent issues, including major and minor incidents. The policies will apply to our own Case Managers and our contracted providers and will be consistent with Iowa code.

Attachment 5 – Section 9.1.7, Question 2 [SOW 9.1.7]

2. Describe the system that you will use to integrate and share information about members to facilitate effective care coordination

WE USE LEADING INFORMATION TECHNOLOGIES TO COORDINATE CARE

Committed to Health Care Transformation in Iowa

The higher quality, integrated care we will offer members is built upon information systems that help directly support members and give providers and our staff the information they need to do the right thing at the right time for the member. More importantly, these technologies provide the information at the point of decision-making, supporting our stewardship role. Aetna Better Health's care coordination activities are supported by leading edge technologies implemented exclusively by Aetna Medicaid. These include our CORE application and our Care Management Information System, a fully integrated information system for the care management of members with physical or behavioral health issues. Four tools that members or providers will use directly include:

1. **Member website.** The member website helps members get information when and where they need it. It is compatible with Section 508 of the Americans with Disabilities Act and is optimized for use with mobile devices. Included are features such as provider search, Member Handbook, covered services and benefits, information on how to file complaints and appeals, community resources, information on Case Management, and how to contact us.

   [redacted] **- CONFIDENTIAL**

3. **Provider portal.** Providers use the portal, which includes both public and protected sections, to access the provider manual, obtain program updates, enter or check the status of prior authorization requests, check member eligibility, list their panel members, find other Aetna Better Health participating providers for referrals, and check the status of claims they have filed.
4. **Utilization Management Web Interface.** An integrated, secure web-based system will let providers submit all of the necessary information for an authorization request online. This comprehensive, rules-based utilization review and authorization system simplifies and automates the review process, providing timely responses to requests.

And four technology tools that are used by health plan staff include:

1. **Care Management Information System.** A fully integrated information system for physical and behavioral health care management provides a complete suite of functional, physical, and

behavioral health assessments, care planning tools, and monitoring functions. With this system, an Aetna Better Health Case Manager can develop a holistic picture of the member, create a Care Plan that meets the member's needs, goals, and desires, and follow up to evaluate a program's effectiveness and make appropriate changes when necessary. Through remote access capability, the Case Manager can do this while face-to-face with the member in the field, allowing him or her to immediately answer questions, verify information, and take action.

2. **Predictive Modeling.** CORE is Aetna Medicaid's proprietary, evidence-based, custom-developed tool for identifying members who will benefit most from our ICM program. CORE identifies members who are most at-risk, and identifies members according to three high-risk groups: general high-risk, high-risk of an emergency department visit, and high-risk of an inpatient admission. CORE was developed specifically for use with the Medicaid population. A new capability added to CORE uses race and ethnicity factors to identify members who need outreach and management because of risk factors.
3. **General Business Application System.** QNXT™ is our core operating platform. A set of 28 integrated system modules track eligibility, adjudicate claims, manage benefit packages, and support other general member and provider data management and reporting. While QNXT is in broad use across the industry, the original product was designed for the needs of Medicaid, and Aetna Medicaid configures and extends the system to support specific contract needs. EDM, the Encounter Data Management System, integrates with QNXT to manage the validation and submission of encounter data to the Agency.
4. **Integrated Care Engine.** Aetna Medicaid has a dedicated data warehouse and analytics team. The warehouse—our Integrated Care Engine—aggregates data from many systems to provide reports and analytical capability to make better clinical and business decisions. It enables the predictive modeling capability of CORE. We designed this warehouse to meet the needs of Medicaid and can easily meet new needs as they arise; for example, integrating lab or radiology data. Using the Integrated Care Engine, our management team has the information to make effective decisions and to help DHS analyze program design changes when necessary.

Please refer to our response to Attachment 5 – Section 13 for more information on these solutions and others.

9.1.8 Monitoring

Attachment 5 – Section 9.1.8, Question 1 [SOW 9.1.8]

1. Describe your care coordination monitoring strategies.

Our care coordination monitoring program evaluates our effectiveness at the member level, the program level, and the population level. The population-level evaluation examines our overall health plan effectiveness at improving quality and reducing avoidable costs. Aetna Medicaid conducts a comprehensive assessment of the effectiveness of its care and chronic condition management programs annually. We measure member enrollment, engagement, and satisfaction to look for opportunities to improve integrated care management services. Aetna Better Health plan staff will annually review and update the ICM processes and resources to address member needs and identify any opportunities for improvement.

We track health plan performance through Health care Effectiveness Data and Information Set (HEDIS), the Consumer Assessment of Health care Providers and Systems (CAHPS®) Survey, and other performance measures as indicated by contract or deemed appropriate. To evaluate care management, we use utilization data, HEDIS metrics, member and provider satisfaction surveys, complaints and

grievances data, health survey data, and internal quality monitoring reports. We build quality requirements into our provider contracts, and evaluate their performance against expectations.

CARE COORDINATION METRICS AND MONITORING APPROACH

We evaluate our care management process and outcome measures at the departmental level and through our Quality Management program. In addition to specific care coordination metrics, Aetna Better Health of Iowa will measure the performance of the Care Management program through the following metrics:

- Utilization Metrics – readmission rates, bed-days, ED utilization
- Number of referrals by source
- Number and types of cases opened by line of business
- Operational and performance metrics for each Case Manager
- Number and percentage of members in nursing facility placement and receiving LTSS services
- Member satisfaction with Care Management
- Health survey responses (e.g., SF10, SF12)

Specific objectives we monitor include:

- Decreasing avoidable inpatient utilization
- Decreasing avoidable emergency department utilization
- Transitioning members back to the community from institutional settings
- Improving access to behavioral health care when needed
- Increase appropriate utilization of outpatient services
- Improve active participation rates
- Appropriate use of preventive measures like influenza vaccines
- Better methods of adherence, aimed at resulting in better perceived quality of life
- Improvement in HEDIS measures
- Improvement in clinical indicators specific to the condition being managed

Data Point

The Arizona Managed plan successfully increased seven-day follow-up after a psychiatric inpatient discharge from 33.80% in 2011 to 72.7% in 2013.

We also measure the quality of care coordination staff engagement with members. Each month, care management supervisors audit Case Manager records to verify completion of specific activities and the accuracy of documentation. We also track progress on meeting member goals as specified in the Care Plan. These audits may include reviewing member files in our Care Management Information System as well as monitoring telephone conversations with members. We monitor for completeness of documentation and compliance with timeframe standards. Each Case Manager must achieve a minimum score of 90% for completeness of documentation. If he or she does not meet the 90% standard, we initiate education and may take other performance management actions.

Care Management indicators monitored, monthly, include:

- Percentage of membership outreached and participating in Care Management
- Distribution of active cases – % of intensive, % of supportive
- Caseloads by Case Manager
- Success rates for and timely completion of initial and annual assessments
- Percentage of members who opt out of Care Management

- Number of members by level of nursing facility placement
- Number of members receiving HCBS services
- Percentage of non-LTSS members in CORE Group 4 that participate in Care Management

We also monitor program effectiveness. Our care coordination program follows and goes beyond requirements established through NCQA Health Plan accreditation, and includes the following program-level review elements:

- **Case Manager Performance accountability:** Daily, weekly, and monthly, we monitor performance for individual Case Managers using standardized reports and audit tools to measure program compliance with contractual requirements, NCQA standards, and care management business rules. Our systems promote compliance by prompting Case Managers to conduct timely reassessments and tracking all communications with members. Our system Parking Lot allows us to track specific items that have been triggered by the assessment and helps Case Managers work with members to incorporate those items into the Care Plan.
- **Quality Audits:** Care Management supervisors audit their staff to determine if they are following through on member-raised issues or concerns and that they are completing documents correctly. This may include review of member files in our Care Management system as well as monitoring telephone conversations with members. Each staff member must meet or exceed the goals established by the department. Staff members who do not meet or exceed department goals receive additional training with specific performance improvement goals. They are then mentored to improve and monitored more frequently until goals are met.
- **Inter-rater Reliability:** We conduct and document Inter Rater Reliability (IRR) reviews of care management assessments for members receiving LTSS services. These results are reported to our Medical Directors. IRR audits evaluate the consistent application of review criteria and confirm that care management staff are making consistent decisions when applying criteria for service authorization decisions. We also work to make certain consistency of service decisions in accordance with our policies on conflict-free case management.
- **Satisfaction Survey:** We conduct an annual member satisfaction survey to obtain feedback from members about their experience with integrated care management and chronic condition management. We use the survey results to look for opportunities to improve the effectiveness of our clinical staff and member satisfaction with our care management programs.
- **Care Management Steering Committee:** Aetna Medicaid's Care Management (CM) Steering Committee oversees and approves development, implementation, and continuous improvement of Aetna Medicaid's integrated care management and chronic condition management programs and services. The CM Steering Committee oversees all ICM programs and services to monitor that we are delivering member-centered services for the member and their family/caregivers; adhering to the core set of biopsychosocial principles and evidence-based practices endorsed by Aetna Medicaid; measuring and improve clinical and utilization outcomes for members; meeting NCQA, state, and federal requirements.

OUR CARE COORDINATION IS CLOSELY LINKED TO QUALITY MANAGEMENT

Monitoring the quality of the care coordination program is integrated into Aetna Better Health's Quality Management program. Quality Management is responsible for monitoring, evaluating, and improving the continuity, coordination, quality, accessibility, availability, and timely utilization of health care and services provided to members. Our quality improvement principles and activities are plan-wide. We

integrate Care Coordination data monitoring and improvement metrics into Quality Management through inter-departmental monitoring processes and activities.

Aetna Better Health's Utilization Management and Quality Management Departments monitor data to detect patterns of over- and under-utilization. Clinical assessments identify gaps in care that indicate potential under-utilization of clinical services. Examples of gaps are missed prenatal visits for high-risk pregnant members, or missing preventive services for members in our chronic condition management program.

Attachment 5 – Section 9.1.8, Question 2 [SOW 9.1.8]

2. Describe how case specific findings will be remediated.

We will use both plan-wide and member-specific approaches to remediate specific case findings or areas of non-compliance. We have discussed our overall approach for monitoring care management services and remediating systemic issues in our response to Attachment 5 – Section 9.1.8, Question 1 above.

For individual members, we use processes to reduce gaps in care approach as discussed in our response to Attachment 5 – Section 9.1.6, Question 9. Our "parking lot" method works through case findings for members with multiple conditions and concerns. Our members have many health and services issues, often more than they wish to discuss and address in a single contact with our Case Managers. To address this, we work with each member to first address his or her priority issues, then commit to addressing any additional case findings over the course of our relationship with the member. We use our assessment process to identify all of the member's needs and concerns. The parking lot field on our case management screens tracks issues that are still pending or open. At each member contact we identify case findings, or issues from the parking lot, to address with the member.

For issues identified during a visit or assessment, Case Managers have tools and strategies to remediate case findings or gaps. The evidence-based assessments often identify gaps in services and generate alerts for routine service needs. To remediate the problems, the Case Manager may:

- Notify a provider of a needed clinical service by making a call or sending an e-mail
- Contact a service provider to discuss a single gap or pattern of gaps, identify the reason for the gaps, and discuss changes that the service provide will make to prevent such gaps in the future
- Make changes in the Care Plan to make certain more consistent delivery of services

Our Interdisciplinary Care Teams enable us to evaluate issues from multiple perspectives (including the member's) and identify solutions that meet the member's needs. Aetna Better Health of Iowa will monitor care coordination processes with the frequency required by the Agency. We will continue to implement strategies to continuously improve our care coordination program and to resolve any areas of non-compliance.

9.1.9 Reassessments

Attachment 5 – Section 9.1.9, Question 1 [SOW 9.1.9]

1. Describe in detail your process for reviewing and updating care plans.

WE UPDATE CARE PLANS AS NEEDED TO MEET PATIENT NEEDS

For members at the intensive level of ICM service, Aetna Better Health Case Managers review the member's Care Plan every 30 days. We review goals and services provided at that time, and may revise them if needed. We review the Care Plan for members enrolled in the Supportive level of ICM every 90 days. The review assesses appropriateness of the level of care and services provided to the member. Our process for review and update of the Care Plan includes:

- Discussion with the member, including discussion of the member's experiences and satisfaction
- Reassessment, using our Care Plan Interview with Clinical Assessment Tools needed for the member's condition
- Review of elements in the Plan: goals, progress, satisfaction, services and supports, effectiveness of community services, access, cultural alignment with the member's needs and preferences
- Meeting of the Interdisciplinary Care Team or the member's providers, if needed
- Convening Aetna Better Health case review for complex cases, if needed
- Documentation of findings and interventions in our Care Management Information System

We also update the Care Plan as needed if there is a change in patient status or circumstances. Our answer to Question 3 below discusses the triggers for reassessment. We identify these changes through member contact, monitoring of claims, provider, caregiver or member referral, hospitalization, or member self-reporting. We document patient needs and identify needed changes to the Care Plan at the time of update. We conduct comprehensive reassessments at least annually.

For additional details, please refer to our response to Attachment 5 – Section 9.1.3, Question 1.

Attachment 5 – Section 9.1.9, Question 2 [SOW 9.1.9]

2. Describe the protocol that you will use for re-evaluating members to determine if their present care levels are adequate.

CARE NEEDS ARE DRIVEN BY ASSESSMENTS AND MEMBER NEEDS

Assessment and reassessment determine the level of care and services required for each member. Reassessment also considers the dynamic changes in each member's life. The frequency of follow-up contact and Care Plan reviews is determined by the member's stratification level and driven by the complexity of their health conditions.

We review the Care Plan at least monthly for members at the intensive level of care, and at least quarterly for members at the supportive level. As the member's required level of care changes, we work with him or her to establish the appropriate services and coordination activities, including moving the member to a higher or lower level of care, if appropriate.

Attachment 5 – Section 9.1.9, Question 3

3. Indicate the triggers which would immediately move the member to a more assistive level of service

WE ANTICIPATE AND RESPOND TO MEMBER NEEDS FOR ASSISTANCE

The assessment and re-assessment process informs our understanding of the level of care and services required for each member and considers the dynamic changes occurring in each member's life. Our CORE predictive modeling stratifies members according to the level of assistance they need.

Triggers that will move the member to a more assistive level of service may include the following:

- Member has recurrent emergency department visits, frequent avoidable physical or behavioral admissions, or increasing frequency of behavioral crises
- Member has a significant change in condition, medications, or placement warranting a higher or lower level of monitoring.
- Member or provider calls with an emergency or urgent referral

When a trigger event occurs, we contact the member within two business days (no later than 72 hours) of being notified of the event or change in status. Our Case Manager will assess the member to determine if she or he needs a more assistive level of service. If so, the Case Manager will work with the member's primary provider (or specialist if serving in that role) to move the member to the needed level of care. We may interface with crisis or emergency personnel as well.

Events that will lead to an assessment that may changes in the level of care include:

- Information, concerns, or issues provided by the member's family or caregiver, PCP, Health Home, Integrated Health Home, or other involved providers
- Enrollment transition information from each member's caregiver, PCP, Health Home, Integrated Health Home, or other provider as appropriate
- Identified gaps in the member's care that are related to evidence-based practice guidelines
- Discharge plan from an inpatient setting or nursing facility
- Information received through claims monitoring that specific services, such as an unexpected inpatient stay or a visit to the ED, have occurred
- Identification of a new chronic condition
- A complex acute event that-risks worsening any underlying disorder or makes care management more complex
- A trauma-related event or incident
- Transition of care event

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Section 10: Quality Management and Improvement Strategies

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SECTION 10 – QUALITY MANAGEMENT AND IMPROVEMENT STRATEGIES

The table below outlines how the Scope of Work provided in RFP Attachment 1 relates to the responses to the questions provided in RFP Attachment 5. We provide this table to reduce redundancy of responses and information and to simplify the evaluation process for the evaluators.

For requirements in Attachment 1 that do not require a detailed response, the table below indicates our intent to comply with the stated requirement in lieu of repeating the RFP question and including a will comply statement within the body of the narrative.

Attachment 1 requirement	Cross reference to Attachment 5	Will comply
10.1 Contractor Quality Management/Quality Improvement (QM/QI) Program	Section 10.1, Questions 1, 4	Yes
10.1.1 Program Objectives	Section 10.1, Questions 1, 2, 3	Yes
10.1.2 QM/QI Program Requirements	Section 10.1, Questions 1, 2, 3	Yes
10.1.2.1	Section 10.1, Question 1, 2, 3	Yes
10.1.2.2	Section 10.1, Question 1	Yes
10.1.2.3	Section 10.1, Question 1	Yes
10.1.2.4	Section 10.1, Question 1	Yes
10.1.2.5	Section 10.1, Question 1	Yes
10.1.2.6	Section 10.1, Question 1	Yes
10.1.2.7	Section 10.1, Questions 1 and 4	Yes
10.1.2.8	Section 10.1, Question 1	Yes
10.1.2.9	Section 10.1, Question 1	Yes
10.1.2.10	Section 10.1, Questions 1, 2, 3	Yes
10.1.2.11	Section 10.1, Questions 1, 2, 3	Yes
10.1.2.12	Section 10.1, Questions 1, 2, 3	Yes
10.1.2.13	Section 10.1, Questions 1, 2, 3	Yes
10.1.2.14	Section 10.1, Questions 1, 2, 3	Yes
10.1.2.15	Section 10.1, Question 1	Yes
10.1.2.16	Section 10.1, Questions 1, 4	Yes
10.1.2.17	Section 10.1, Question 1	Yes
10.1.2.18	Section 10.1, Questions 1, 3	Yes
10.1.3 QM/QI Committee	Section 10.1, Question 5	Yes
10.1.3.1 Minutes	Section 10.1, Question 5	Yes
10.1.3.2 Notice of Meetings	Section 10.1, Question 5	Yes
10.2 State Quality Initiatives	Section 10.2 Introduction	Yes
10.2.1 State Quality Review	Section 10.2 Introduction	Yes

Attachment 1 requirement	Cross reference to Attachment 5	Will comply
10.2.2 External Independent Review	Section 10.2 Introduction	Yes
10.2.2.1 External Review Goals	--	Yes
10.2.2.2 Process	--	Yes
10.2.2.3 Availability of Results	--	Yes
10.2.3 Healthiest State Initiative	Section 10.2, Questions 1 and 5	Yes
10.2.4 Mental Health and Disability Services Redesign	Section 10.2, Question 2 and 5	Yes
10.2.5 State Innovation Model (SIM)	Section 10.2, Question 3 and 5	Yes
10.2.6 Substance Abuse Prevention and Treatment Block Grant	Section 10.2, Question 4	
10.3 Incentive Programs	Section 10.2, Questions 4 and 5	Yes
10.3.1 General	Section 10.3, Questions 1 and 2	Yes
10.3.2 Provider Incentive Programs	Section 10.3, Questions 1 and 2	Yes
10.3.2.1 General	Section 10.3, Question 1	Yes
10.3.2.2 Incentive Payment Restrictions	Section 10.3, Question 1	Yes
10.3.3 Member Incentive Programs	--	Yes
10.3.3.1 General	Section 10.3, Question 2	Yes
10.3.3.2 Incentive Payment Restrictions	Section 10.3, Question 2	Yes
10.4 Critical Incidents	--	Yes
10.4.1 General	Section 10.4, Questions 1 through 4	Yes
10.4.2 Provider Requirements	Section 10.4, Questions 1 through 4	Yes
10.4.3 Training	Section 10.4, Questions 1 through 4	Yes
10.4.4 Corrective Action	Section 10.4, Question 2	Yes
10.4.5 Monitoring	Section 10.4, Question 3	Yes
10.5 Provider Preventable Conditions	Section 10.4, Question 4	Yes
10.5.1 General	Section 10.5, Question 1	Yes
10.5.2 Provider Requirements	Section 10.5, Question 1	Yes

10.1 Contractor Quality Management/Quality Improvement (QM/QI) Program

Please explain how you propose to execute Section 10 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Aetna Medicaid plans administer quality programs for nearly three million Medicaid members across 17 states. Aetna Better Health of Iowa, Inc. (Aetna Better Health) will build on this expertise to implement our contractor Quality Management/Quality Improvement (QM/QI) program in Iowa.

A quality system to achieve better health outcomes for Iowa

Aetna Better Health and Aetna Medicaid have a broad perspective on quality management and will bring that perspective to the Iowa High Quality Healthcare Initiative. This encompasses a *quality system* with six primary elements, as follows:

- **Commitment to quality throughout the organization.** Our commitment to quality in everything we do begins with Pamela Sedmak, the Chief Executive Officer (CEO) of Aetna Medicaid, and extends through the senior management team and all of the leadership, management, and staff of Aetna Medicaid and the health plans. Quality is everyone's job; it is not confined to the QM/QI Department of the health plan. Everyone in the organization has performance incentives that are directly linked to achieving quality results.
- **The member's health is paramount.** Quality is often defined as "conformance to customer expectations." For us, the member's health is the paramount customer expectation—how do we work to help achieve the best outcomes for each member? We need to fully understand the expectations of all customers of our services: members, providers, the Agency, and other program stakeholders. These expectations are defined in many ways: the RFP, the Contract, state and federal law and regulation, NCQA accreditation standards, HEDIS® (registered trademark of NCQA) and CAHPS® (registered trademark of the Agency for Healthcare Research and Quality) benchmarks, Health Insurance Portability and Accountability Act (HIPAA), and many others. For the member, though, these statements and standards are simply not enough to fully define what we must achieve. Programs to improve overall population health status and to serve populations such as those who need long term services and supports (LTSS), Intellectual/Developmental Disabilities (I/DD), dual eligibles, and others expand the needs we must consider. Every department in our organization learns about and adheres to the requirements applicable to their business functions; every department also engages in ongoing exploration to determine what changing, new, or emerging standards might apply and sets new levels of expectation for their work.
- **Aligned goals and incentives among stakeholders.** Members, providers, and health plans each have responsibilities within the health system. Our quality system provides incentives and approaches that align behaviors throughout the system and link to Iowa's goals and objectives for the program. Thus, the system will work to engage members to influence appropriate health choices and decisions outside the clinical interactions they have with providers. We will also offer a Value-Based Purchasing (VBP) program to providers that combines incentive payments with tools and reporting to help providers make decisions that are consistent with the best clinical practice for a member.
- **Well-defined systems and processes to deliver our services to customers.** Each function within Aetna Better Health and Aetna Medicaid relies on reference documentation, including policies and procedures, process designs, system specifications, and others that clearly define the inputs and outputs for each business process. Extensive training helps every person in the organization know what they are to do, how to do it, what tools are used to do it, and how to assess their work.
- **Measuring, monitoring, and reporting results and internal process indicators.** These tools include measurement systems such as HEDIS and other internal measures, such as those for claims processing and call center performance. To measure results, we use both manual and automated data collection methods, capture the data in our information systems, run both periodic and ad hoc reports to understand operations and to monitor trends and patterns, and analyze results to understand potential opportunities or problems.

- **People who know how to do the work and improve the system.** We recruit, hire, and train individuals for each job position who have the right knowledge, skills, and experience to perform the work and who will exemplify and uphold Aetna's values. Everyone must attend comprehensive training: classroom, web-based, self-directed, virtual, and on-the-job training as applicable to the job. Coursework covers both the information needed for their jobs, as well as information on quality requirements and techniques for that job.

"In my medical practice, I could only impact one patient at a time. As a steward of Aetna Medicaid's quality program, I can now make a positive impact on three million members through our quality programs."

Sandra White, M.D.
Executive Director, Health Care Quality, Aetna Medicaid

Attachment 5 – Section 10.1, Question 1 [SOW 10.1.1, 10.1.2]

Describe your Quality Management and Improvement Program, addressing all elements outlined in Section 10.1.2. Include how you will monitor, evaluate and take effective action to identify and address any needed improvements in the quality of care delivered to members.

QM/QI purpose and objectives [SOW 10.1.1]

The Aetna Better Health QM/QI program will be a fully integrated program for managing, monitoring, evaluating, and improving the quality of care and services for all of our members. Our QM/QI Department will monitor care delivery systems, identify potential areas of concern, and direct interventions for improvement. Our QM/QI efforts reach beyond the traditional health plan clinical quality approach, making best use of the technology and services to accelerate the transformation of health care.

Our program will encourage a member's responsibility for their health status and will reward providers based on health outcomes and meaningful quality metrics. The QM/QI program will benefit from input from participants in oversight committees with representation from stakeholders, including participating providers and our members.

QM/QI program structure

Committed to Health Care Transformation

Continuous quality improvement and metrics are part of everything we do. QM/QI will be an integral component of our operational management in Iowa as we enhance health outcomes and demonstrate value and quality as returns on investment. We will integrate quality improvement principles and activities through interdepartmental monitoring processes and activities, such as:

- Referrals of quality and risk issues
- Member and provider grievances
- Shared management information systems, business application systems, and databases
- Structure of oversight committees with interdisciplinary departmental representation and representation from state and community agencies, the provider network, and members

QM/QI program requirements [SOW 10.1.2]

Aetna Better Health will adhere to standards of the NCQA and will participate in the Health Plan Accreditation program to demonstrate our commitment to continuous quality improvement and meeting customer expectations. We will produce HEDIS and CAHPS® reports annually and submit them to NCQA for public reporting and accountability. Aetna Medicaid is committed to achieving NCQA

accreditation for all of the health plans owned by Aetna, Inc., whether or not accreditation is required by that state.

Aetna Medicaid health plans in other states have achieved NCQA accreditation, and we will learn from their experiences and knowledge as we pursue accreditation for Iowa. The policies and procedures to be developed for Aetna Better Health will reflect all necessary elements related to the requirements set forth by NCQA.

Currently, Aetna Medicaid has nine Medicaid plans with NCQA accreditation. Aetna Inc., our corporate parent, has another 182 accredited plans operating across the United States. Tables 10-1 and 10-2 show NCQA accreditation.

Table 10-1: Aetna Medicaid health plans with NCQA accreditation

Aetna Medicaid plans	Accreditation status
Florida, Michigan, Missouri, Virginia	Commendable
Kentucky, Nebraska, Pennsylvania, West Virginia	Accredited
Maryland	Interim
Illinois, Louisiana, New Jersey, New York, Ohio, Texas	In process of preparing for or seeking accreditation

Table 10-2: Beyond Medicaid, many Aetna, Inc. health plans have achieved NCQA accreditation

	Medicaid HMO	Medicare PPO	Medicare HMO	Commercial PPO	Exchange PPO	Commercial HMO/POS	Exchange HMO/POS
Number of health plans	9	34	24	59	18	37	10

ANNUAL AND PROSPECTIVE WORK PLANS [SOW 10.1.2.1]

Our QM/QI work plan will be the blueprint for improving the quality of health care and services in Iowa. We will use annual and prospective work plans to set measurable goals, establish specific objectives, identify actionable strategies and activities, monitor results, and assess progress. As a new plan in Iowa, Aetna Better Health's measurable goals will be set using NCQA Quality Compass® (registered trademark of NCQA) national or regional 50th percentile benchmarks with the objective to improve each year. Our strategies will include organization-wide awareness and participation in QM/QI activities, engagement of staff, providers and members, and participating in quality improvement projects directed by Iowa Department of Human Services (the Agency), as well as clinical and non-clinical improvement initiatives that align with Iowa's state quality initiatives.

ANNUAL QM/QI PLAN

Appendix M is our draft annual QM/QI plan. The plan specifies projected quality management and performance improvement activities, designated staff positions or department responsibilities, and the resources required to complete the work plan within the anticipated timeframes. We will review and update the plan at least quarterly. We also use the plan to monitor our progress in influencing safe clinical practices across the network. The QM/QI Director will develop the plan and submit it for approval to the Quality Management/Utilization Management (QM/UM) Committee and the Quality Management Oversight Committee (QMOC).

As we manage health care services, we will regularly review and monitor results. If we find an unexpected trend in the data, we will act on opportunities for improvement and modify the coming year's clinical programs as necessary. Upon completion of the annual QM/QI evaluation, we will develop specific quality management and performance improvement goals for the coming year. These goals draw from the opportunities identified in the evaluation as well as those articulated by the Agency or other key stakeholders. These goals and recommended changes will then be incorporated into the subsequent year's program and work plan.

We will create an annual report of our QM/QI activities that documents completed studies, evaluates results, outlines recommended and implemented subsequent actions, and aggregates relevant data. We will submit this report to the QM/UM Committee and the QMOC, then to the Aetna Better Health Board of Directors for approval; we will then forward the report to the Agency for review and approval.

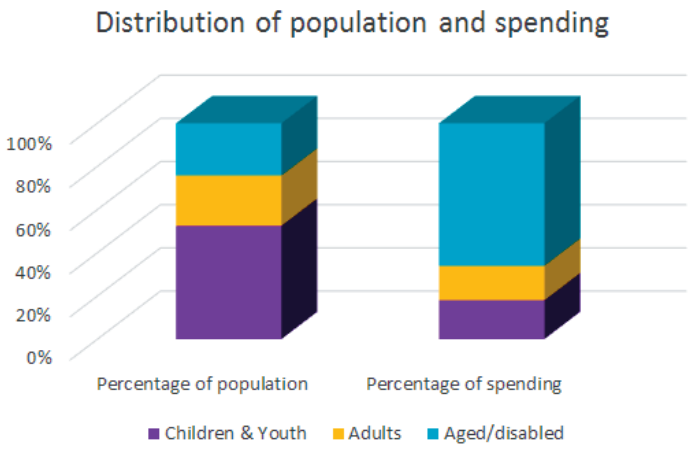
PROSPECTIVE QM/QI PLAN

Aetna Better Health will develop a prospective five-year QM/QI plan for review and approval by the Agency. We will design this based on a framework of metrics and programming that support improvements and align with Iowa's Healthiest State initiative, Mental Health and Disability Services Redesign, the testing phase of the State Innovation Model (SIM), and the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant.

In their Fiscal Year 2015, the Agency expects to serve nearly 800,000 persons or 26% of Iowa's total population through the Iowa Medicaid enterprise. Effective QM/QI will be essential for sustaining high-quality care and improving health outcomes, while controlling costs. We have reviewed publicly available statistics and performance measures to assess opportunities for improvement of health outcomes in the populations served by the Agency. We will align our planning with Iowa's current methods for segmenting its Medicaid population to address the following (see Figure 10-1):

- On average, 52% of Iowa's Medicaid beneficiaries are children and youth who account for 18% of total spending annually. Opportunities for improvement include facilitating access to preventive care (immunizations, well care), assessment of body mass index (BMI) and referral for counseling and weight management, as well as promotion of positive health behaviors.
- Adults represent an average of 23% of beneficiaries and account for 16% of total spending annually. Opportunities for improvement include increased adherence to preventive care guidelines and prevention of chronic conditions, as well as promotion of positive health behaviors in nutrition, physical activity, weight management, and tobacco cessation.

Figure 10-1: Distribution of Iowa Medicaid population and spending



- About 24% of beneficiaries are aged or disabled, and they account for 66% of total spending annually. There are significant opportunities for improving health and lowering costs in this segment. We have a well-developed model to manage biopsychosocial complexities and to involve members in developing effective choices and accessing home or community-based care and the appropriate long-term supports they need to maintain quality of life.

In the responses to questions in Section 10.2: State quality initiatives, we provide additional details on activities and programs that align with Iowa's key initiatives.

DEDICATED RESOURCES AND ACCOUNTABILITY [SOW 10.1.2.2]

Aetna Better Health will have a local QM/QI Department with dedicated staffing, data sources, and analytical resources to coordinate QM/QI functions and activities across multiple departments. Aetna Medicaid Informatics population Health Analytics and Outcome Evaluation Departments will provide data management and analytical support. The Aetna Better Health CEO, Chief Medical Officer (CMO), the QMOC, and our Board of Directors will provide leadership, with advisement and recommendations provided by formal medical committees, subcommittees, and ad hoc work groups (described in detail below).

QM/QI DEPARTMENT

Under the direction of the CEO, the QM/QI Department will coordinate quality management and improvement and provide administrative support for the various quality committees. Department responsibilities will include:

- Coordinate and support quality management processes and monitoring activities
- Coordinate as necessary with Case Management, Utilization Management, and other Aetna Better Health departments to carry out quality improvement projects (QIPs)
- Maintain databases for tracking quality of care or service issues, trends, and issue resolutions
- Develop and monitor the annual QM/QI work plan and revise as necessary
- Coordinate activities to prepare the annual QM/QI evaluation
- Review and investigate information related to potential quality of care issues (peer review)
- Coordinate with the External Quality Review Organization (EQRO)

Our QM/QI Department will coordinate evaluation and follow up on contacts from members, providers, state or regulatory agencies, or other referral sources and will serve as the central area for receiving and responding to potential quality or risk management and compliance issues and for coordinating QM/QI activities across Aetna Better Health services and programs.

The Director of QM/QI will oversee the department, supported by several staff members. In hiring, we prefer applicants with Medicaid experience. Table 10-3 summarizes positions and responsibilities.

Table 10-3: Aetna Better Health QM/QI key staff

Position	Responsibilities
Director	• Oversee implementation of the strategic and operational QM/QI plan • Coordinate policies and procedures throughout the health plan • Manage QM/QI operations focused on improving clinical and financial outcomes, member engagement, and satisfaction • Serve as a technical, professional and business resource to other departments • Oversee QM/QI staff

Position	Responsibilities
Quality Measurement and Reporting Manager	• Serve as the lead in oversight of all aspects of HEDIS QI project implementation, including budget development and supervision of staff participants, and the design of data collection methodology and metrics to measure outcomes • Develop cross-functional workgroups to design and implement QI initiatives • Develop documentation templates and systems to support QM projects and initiatives • Educate and consult with other departments on QI methods (workflow, data analysis, metrics) • Translate and deliver business information to internal and external constituents through formal presentations or written communications
Accreditation and EQRO Audit Manager	• Set priorities and make recommendations for the design, development, and implementation strategies for QI projects related to NCQA accreditation • Lead cross-functional workgroups to design and implement QI initiatives related to NCQA accreditation • Develop documentation templates and systems to support QM projects and initiatives • Educate and consult with other departments on quality improvement methods (workflow, data analysis, metrics) • Translate and deliver business information to internal and external constituents through formal presentations or written communications
Prevention and Wellness Consultants	• Support the development and ongoing implementation of QM/QI activities related to early and periodic screening, diagnosis, and testing (EPSDT) • Coordinate Aetna Better Health activities to promote access to timely preventive and well care through targeted member or provider education and outreach initiatives • Monitor performance against state and federal standards for health education and preventive care • Develop recommendations and options for improving performance
QM/QI Nurse Consultants	• Review and evaluate clinical information and documentation • Interpret data obtained from clinical records or systems • Apply appropriate clinical criteria and policies in-line with regulatory and accreditation requirements to address member or provider issues • Coordinate resolution of clinical issues, with internal and external clinician support as required • Report evaluation or clinical findings to appropriate staff or others to verify appropriate outcome or follow up for improvement

NATIONAL AETNA MEDICAID QUALITY MANAGEMENT (QM) DEPARTMENT

The National Aetna Medicaid QM Department will provide oversight, support, and resources to Aetna Better Health. This unit includes four teams that are responsible for:

- Creating and maintaining programs and systems to support QM/QI programs
- Assisting us with problem-solving and development of solutions
- Disseminating best practices
- Defining minimum business practices for QM/QI

INFORMATICS

The Aetna Medicaid Informatics Population Health Analytics and Outcome Evaluation Departments will support our QM/QI program. Informatics Population Health Analytics team will analyze health and financial information to develop insights that support business decision-making about health care costs and trends, quality and outcomes. They will extract, collect, analyze, and interpret outcome, utilization, and financial data of various types from many sources. Informatics Population Health Analytics team will use the results to address business questions regarding population health management, health and economic outcomes, quality of healthcare, and healthcare program and product design. These activities

require advanced technical, analytic, and consultative skills and an understanding of epidemiology, health care benefits, health care financing, health care delivery, and health data information systems.

The Outcomes Evaluation team, a subset of the Informatics Population Health Analytics team, will provide technical support and analyses for monitoring and evaluation of QM/QI performance improvement activities. Such support will include data management and statistical analyses to support the effective measurement of performance and execution of improvement projects.

LEADERSHIP: CEO AND CMO

The Aetna Better Health CEO will be accountable for directing the development and implementation of QM/QI activities and will oversee QM/QI performance activities to meet QM/QI goals and objectives. The Aetna Better Health CMO will provide consultative expertise regarding clinical quality. The CMO will be a board-certified or board-eligible, Iowa-licensed physician who is familiar with local and nationally accepted standards of practice. The CMO will lead strategic medical management activities that contribute to the performance of the health plan and promote quality of care for our members. These activities include development and implementation of medical programs and policies; development of medical cost and return on investment analyses; facilitation of relationships with providers, facilities, and regulatory agencies; and service as a key business partner in network development, product design, and strategic planning. The CMO will chair the QM/UM Committee; a designated Medical Director may chair other clinical committees on the CMO's behalf. [SOW 10.1.2.2]

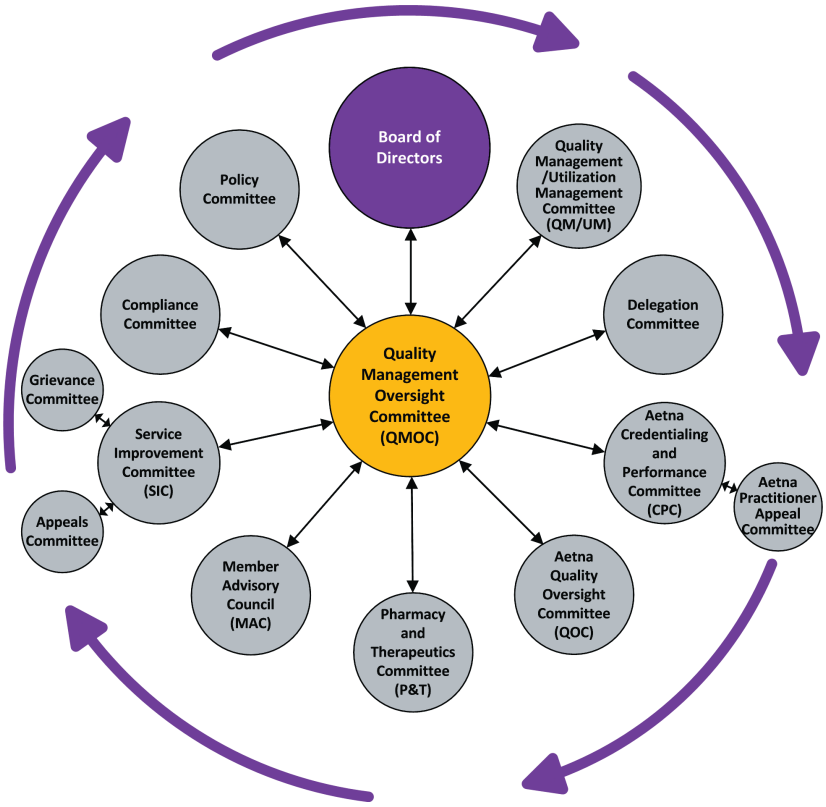
ACCOUNTABILITY: BOARD OF DIRECTORS AND LEADERSHIP

The Aetna Better Health Board of Directors will have ultimate accountability for QM/QI and related processes, activities, and systems. This accountability includes responsibility for implementing systems and processes for monitoring and evaluating the care and services members receive through Aetna Better Health. Operational responsibilities for oversight and implementation are delegated to the QMOC.

QM/QI COMMITTEE STRUCTURES AND MEMBERSHIP

Formal medical committees, subcommittees, and ad hoc work groups will advise the Board of Directors and the QMOC. The committees will integrate our medical functions, operations departments, providers, and members into QM/QI through participation on one or more committees, overlapping membership and leadership responsibilities, and integrated reporting requirements. The QM/QI Department will provide the administrative support for committee meetings and follow-up activities. The QMOC oversees quality activities and integration of QM/QI across Aetna Better Health operations. Figure 10-2 shows the relationships between the QMOC and its various subcommittees. Table 10-6 in Section 10.1, Question 5 describes each committee.

Figure 10-2: Communications structure for QM/QI committees



CONTINUOUS QUALITY IMPROVEMENT

Our QM/QI program and committee structure promotes continuous quality improvement. All of our departments and personnel will contribute to QI/QM. Each department reports performance and monitoring metrics to the QM/QI committees. The committees will collaborate with QM/QI staff to develop and implement QI processes and programs.

- **Member Services** will lead the Member Advisory Committee (MAC), monitor call center performance, incorporate process flows relevant to improving their impact on the member satisfaction survey, and accept and resolve member complaints.
- **Provider Services** will educate providers about QM/QI activities, help implement provider interventions, monitor network compliance with access and availability standards, develop provider profiling and performance reports, and monitor and act upon opportunities for improvement based on the provider satisfaction survey.
- **Utilization Management** (UM) will monitor administrative performance metrics and trends in utilization metrics to inform QM/QI. Section 11 discusses UM processes and metrics.
- **Integrated Care Management** and **Integrated Long-Term Care Management** will monitor the volume of cases opened, managed, and closed; new member assessments; and development of care plans and resulting health outcomes.
  - Aetna Better Health Case Managers will provide the clinical interface with community-based care management teams to identify high- and moderate-risk members with complex health conditions that will benefit from care management services.

  - Case Managers will also work with providers to build programs and interventions for members with complex biopsychosocial conditions that support access to home and community-based services (LTSS) and that support recovery and resiliency (children with serious emotional disturbances and adults with serious mental illness).

- **Grievance and Appeals** will monitor the trends in volume and types of grievances and appeals, volumes by grievance and appeal levels, volumes of appeals overturned, and analysis for the overturned appeals.
- **Information Management** will maintain and support system applications to provide support to the QI/QM program, generating key indicator reports for all operational areas.

ADDRESSING PHYSICAL HEALTH, BEHAVIORAL HEALTH, AND LTSS [SOW 10.1.2.3]

The Aetna Better Health QM/QI program is holistic—it works to improve quality throughout the system and for all classes of services, not just physical health. We measure performance in six domains and work to improve results across all of those domains. See our response to Section 10.1, Question 2 for information on the six measurement domains we use in QM/QI.

DETECTING AND ADDRESSING OVER- AND UNDER-UTILIZATION OF SERVICES [SOW 10.1.2.4]

Our UM Department collaborates with the QM/QI Department to identify both over- and under-utilization of services. We will monitor of patterns of utilization, evaluate those patterns to find root causes, and implement process improvements. Our approach considers the characteristics and health care needs of the member population and the community in which the member lives and receives care. Section 11, Utilization Management, describes our approach.

MONITORING VARIATION IN PRACTICE PATTERNS AND IDENTIFICATION OF OUTLIERS [SOW 10.1.2.5]

Aetna Better Health will develop provider quality performance reports—referred to as practitioner profiles—to identify trends related to cost, quality, and utilization. Profiles assist both Aetna Better Health and providers in monitoring performance measures for overall care and in identifying members with low compliance or complex health care needs. By examining profiles, we will:

- Assess primary care provider (PCP) performance
- Support development of patient-centered, team-based approaches to care through consistent monitoring and evaluation of performance
- Monitor and evaluate pay for quality and total cost of care models
- Support other provider quality and value-based payment efforts

The CMO or designated Medical Director will review the profiles quarterly to evaluate provider utilization and service patterns, trends, and costs during the previous year. If a profile report indicates a deficiency (such as low performance on HEDIS measures), the CMO may ask that provider to develop a corrective action plan.

ANALYSIS OF THE EFFECTIVENESS OF TREATMENT SERVICES [SOW 10.1.2.7]

We evaluate the effectiveness of treatment services by measuring performance in six domains and work to improve results across all of those domains. These domains include standard measures of care as well as functional services. See our response to Section 10.1, Question 2 for information on the six measurement domains we use in QM/QI.

PROMOTING THE USE OF EVIDENCE-BASED CLINICAL PRACTICE GUIDELINES [SOW 10.1.2.6]

Aetna Better Health will use several methods to distribute information to our providers. Our Medical Management and Provider Services staff will educate our providers through the initial provider orientation, scheduled training webinars, provider educational forums, and during scheduled in-service and ad hoc provider office visits. We will also provide information on tools for the effective use of guidelines and updated evidence through our Provider Manual, our provider portal, and periodic provider newsletters. We train our Provider Services Representatives to educate providers, answer their questions, and address provider concerns.

The QM/QI Department will analyze the effectiveness of treatment services based on evidence-based practices and guidelines:

- **Preventive Health Guidelines –** We will have selected pediatric, adult, and pre- and perinatal guidelines for our members. We develop or adopt guidelines that promote safer clinical practice through adherence to nationally recommended standards of preventive care. At least every two years, or more frequently if national guidelines change within the two-year period, our QM/UM Committee reviews and approves the guidelines.
- **Clinical Practice Guidelines –** We use clinical practice guidelines to address standards of care for chronic and acute conditions such as diabetes, asthma, and depression. We developed or have adopted these guidelines with input from the appropriate specialties; these guidelines are reviewed and approved by the QM/UM Committee.
- **Aetna Clinical Policy Bulletins (CPBs) –** CPBs state Aetna's policy regarding the experimental and investigational status and medical necessity of medical technologies and other services, for the purposes of making coverage decisions under Aetna-administered health benefit plans. In making coverage decisions, Aetna's professional staff refer to the member's benefit plan, and if necessary, the CPBs and other Aetna-recognized criteria. Aetna's CPBs are based on evidence in the peer-reviewed, published medical literature; technology assessments and structured evidence reviews; evidence-based consensus statements; expert opinions of health care providers; and evidence-based guidelines from nationally recognized professional health care organizations and public health agencies.

Section 10.1, Question 4 has additional information about our experience and strategies in working with network providers to assess effectiveness of treatment and patient services. Aetna Better Health will also introduce a VBP program to offer progressive pay for quality models that reward providers for delivering high-quality care and will support Iowa's testing phase of the SIM. We explain our VBP program in our response to Section 10.3, Question 1.

MONITORING PRESCRIBING PATTERNS [SOW 10.1.2.8]

Our Pharmacy Utilization Management and Drug Utilization Review program analyze member and provider drug utilization patterns. We will use the results to develop applicable interventions or educational activities to strengthen the integration of pharmacy and care management activities. The program includes:

- Member drug utilization
- Pharmacy dispensing patterns
- Practitioner prescribing patterns
- Drug prior authorization criteria

- Pharmacy Benefit Manager (PBM) oversight activities in maintaining a prospective drug utilization review process for identifying selected safety issues at the time of dispensing

Using pharmacy claims data, our Medical Director and Pharmacy Director will monitor daily, weekly, monthly, and quarterly management reports. Based on these reports and trending analysis, we will implement interventions to improve quality as well as control costs.

By evaluating the results of our targeted interventions, we can determine if we need to make changes to achieve the desired outcomes. We will work with our PBM and Integrated Care Management (ICM) team to offer clinical solutions to improve member health and quality of care, as well as to evaluate opportunities that will reduce total costs. By combining technology and extensive clinical resources, we will direct our PBM to intervene with members and providers to improve safety, reduce inappropriate drug utilization, and promote adherence to evidence-based care.

WRITTEN POLICIES AND PROCEDURES [SOW 10.1.2.9]

Aetna Better Health will develop and maintain written policies and procedures specific to implementation of all of our programs in Iowa. The annual QM/QI plan describes the methods, timelines, and responsibilities for completing policies and procedures. The QM/QI Department coordinates and verifies that policies and procedures are developed, reviewed, and approved for all functions of the plan; individual departments within the plan are responsible for developing those documents for their respective functions.

New staff will receive comprehensive training in all processes and requirements that are described in the policies. For QM/QI functions, the Aetna Medicaid Learning and Performance Department provides training, collaborating with a representative of the National Aetna Medicaid QM Department. Key policies and procedures developed specifically for the QM/QI function include:

- QM/QI Evaluation
- Medical Committee Confidentiality and Conflict of Interest
- Practitioner Education
- Practitioner Oversight
- Consent to Treat Minors
- Practitioner and Provider Performance Data
- Practitioner Profiles
- Pay for Performance (VBP)
- Delegation Oversight Responsibilities
- HEDIS Measurements
- HEDIS Interventions
- Member Satisfaction Surveys
- Prevention and Wellness
- EPSDT
- Family Planning and Reproductive Health
- Vaccines for Children Program
- Quality Management Studies and Performance Improvement Processes
- State Oversight Reviews
- Medical Record Criteria and Documentation
- Review of Potential Quality of Care Concerns and Reporting of Critical Incidents
- Clinical Practice and Preventive Services Guidelines

MONITORING AND ASSESSING QUALITY [SOW 10.1.2.10]

Aetna Better Health QM/QI will monitor and measure the current state of quality using various metric sets, such as HEDIS, CAHPS®, provider satisfaction, and member satisfaction with care management. We will incorporate additional measures defined by Iowa's Mental Health and Disability Services (MHDS) Redesign, the Iowa Chronic Care Health Home, Iowa Health Homes, and the Iowa Medical Home Bonus Program as defined through the SIM. We will use the results to identify areas for improvement, set performance goals for the upcoming year, and develop an action plan for achieving those goals.

We provide a more detailed description of Aetna Better Health processes for monitoring and assessing quality in Section 10.1, in the responses to Questions 2 and 3 below.

CLINICAL STUDIES AND ASSESSMENT OF QUALITY AND APPROPRIATENESS OF CARE [SOW 10.1.2.11]

See our response to Section 10.1, Question 2 for information on how we conduct clinical studies and use data to periodically assess the quality and appropriateness of care provided to members.

IOWA PARTICIPANT EXPERIENCE SURVEY [SOW 10.1.2.12]

To monitor the quality of services and member satisfaction with home and community-based services (HCBS), we will monitor results from the Iowa Participant Experience Survey (IPES) to assess our Integrated Long Term Care Management program, described in Section 4: Long Term Services and Supports (LTSS).

Our approach involves members and their families and caregivers in identifying needs, assessing options for addressing needs, and developing long-range goals for recovery or resilience. Based on Aetna's collective experience, effective development of the case management relationship should yield positive feedback on the IPES, as well as on other member satisfaction and feedback tools that are already a part of our model.

Aetna Better Health will use the interRAI™ tools and methodologies for assessment and monitoring of quality indicators for LTSS. At the individual level, interRAI™ indicators guide development of care plans that address specific member needs. Aggregated interRAI™ indicator data provides summary measures for quality of care at home, in the community, in long-term care, or in assisted living. Clinical assessment protocols have been developed for use with interRAI™ assessments to support collaborative development of care plans for a variety of individual member needs, including behavioral health diagnoses and development of care plans for inpatient or community settings. Assessments are conducted quarterly for members receiving HCBS and semiannually for members in skilled nursing facilities.

By periodically monitoring summary measures, Aetna Better Health can respond more quickly to negative trends and develop quality improvement projects to reverse such trends. In turn, positive trends inform best practices. Use of interRAI™ tools and processes will help us in aligning our QM/QI activities with the performance measure domains in development through Iowa's MHDS Redesign.

REPORTING OF QUALITY AND PERFORMANCE MEASURES [SOW 10.1.2.13, 10.1.2.14]

Aetna Better Health will report performance on Centers for Medicare and Medicaid Services (CMS) key measures and other measures as required by the Agency. We describe these reports in Section 14: Performance Targets and Reporting Requirements. Quarterly, we will monitor member health outcomes, performance measures, and clinical reports and will integrate Value Index Score measures into our QM/QI processes. See our response to Section 10.1, Questions 2 and 3 for a more detailed description of our processes.

ACCURACY, VALIDITY, RELIABILITY OF PERFORMANCE OUTCOMES [SOW 10.1.2.15]

DATA COLLECTION AND STORAGE

We collect data for HEDIS and other measurements by gathering claims and encounter data from providers and subcontractors who offer ancillary services such as laboratory, behavioral health, vision, pharmacy, and dental and validating the data for accuracy and completeness. Similarly, we will collect

and validate the accuracy and completeness of membership data from Agency rosters and provider data from providers and delegated provider credentialing contractors.

We will load claims, encounter, membership, and provider data into our systems as it is collected—daily, monthly, or quarterly, as determined by the type of data. After we validate the data and correct any issues, we load it into the HEDIS Data Mart, our dedicated HEDIS data warehouse. Processes to monitor and analyze the load process help us identify and correct any issues that occur.

MEASUREMENT CALCULATION

Aetna Medicaid's QM/QI Department (which includes the Quality Measurement and Reporting unit and the Quality Performance Intervention and Improvement unit) will work with the Medicaid Informatics HEDIS staff to generate and report HEDIS rates on behalf of Aetna Better Health. Members of this team will have specialized HEDIS expertise; these members include Registered Nurses, Certified Professionals in Healthcare Quality, Project Management Professionals, and Informatics Analysts.

Monthly, the team will produce health-plan specific year-to-date and rolling 12-month reports. By reporting monthly, the team can assess the reasonability and accuracy of their results throughout the measurement cycle; Aetna Better Health can use the data to identify performance issues and then can develop corrective action plans or institute quality improvement projects.

Aetna Medicaid's NCQA-certified HEDIS Compliance Auditor will validate final annual rates and compare the results against prior year reported rates and national Medicaid benchmarks. Aetna Medicaid Informatics will calculate HEDIS measures using NCQA-certified software, which ensures accuracy of the calculations and conformance to NCQA specifications. We use both administrative and hybrid methods:

- The administrative method uses claims and encounters and other administrative data sources to identify the eligible population and those who have received the service required for compliance.
- The hybrid method combines administrative data and data from the member's medical record to determine compliance for a systematic sample of the eligible population for the measure.

We will determine which measures will be reported using the hybrid methodology by applying NCQA technical specifications and Iowa-specific guidelines.

ASSESSMENT OF COLLECTION METHODS

To improve the accuracy of the data collected on member and practitioner race, ethnicity, primary language, disability, and geography, we will validate the collection methods by performing random assessments of the collection processes. We conduct staff performance reviews; assess member, practitioner, and provider records; make telephone calls; and validate data in-person. Our training programs will educate staff, practitioners, and providers about the role of data in improving the health outcomes and quality of care for members. We will use data to verify that we continue to meet member needs such as provider accessibility and availability, translation services, and continuity and coordination of care.

MEDICAL RECORD REVIEW

Aetna Medicaid's QM/QI Department will systematically sample Aetna Better Health members included in the reporting of a hybrid measure in accordance with NCQA HEDIS Guidelines for Calculations and Sampling. After determining the sample of members, the QM/QI Department will calculate measures using administrative data to determine which members are administratively compliant and to determine when additional medical record data are needed.

The result is a file of noncompliant members that we load into a specialized medical record review tool to work with the HEDIS software. We integrate the review results into the HEDIS software, where they are combined with any additional administrative data to produce final HEDIS rates.

We will use professionals trained and experienced in HEDIS to review the medical records and abstract the data for determining measure compliance. We monitor these reviewers using over-reads and inter-rater reliability audits to assess the accuracy and comparability of the abstraction process.

HEDIS COMPLIANCE AUDIT

Aetna Medicaid will contract with a HEDIS compliance audit licensed organization to conduct an annual audit. This organization will verify that our measure determination processes and our information systems and processes used to report HEDIS meet NCQA standards and that our rates are valid and reportable.

PROVIDER PAY FOR PERFORMANCE [SOW 10.1.2.16]

We describe Aetna Better Health's provider pay for performance approach in the response to Section 10.3, Question 1.

MEMBER INCENTIVE PROGRAMS [SOW 10.1.2.17]

We describe Aetna Better Health's proposed member incentive programs in the response to Section 10.3, Question 2.

ADDITIONAL METHODS FOR ASSESSING MEMBER SATISFACTION [SOW 10.1.2.18]

Aetna Medicaid health plans regularly assess member satisfaction with health care services to discover areas that are working well and identify opportunities for improvement. In addition to CAHPS® and IPES, we may conduct additional focused surveys of specific populations or users of identified services. Member surveys may include questions related to availability and accessibility of health care, practitioners, utilization, quality of care and services, care management, disease management, behavioral health, quality of member services, requests to change practitioners or sites, and cultural competency.

Attachment 5 – Section 10.1, Question 2 [SOW 10.1.1, 10.1.2.1, 10.1.2.10, 10.1.2.11, 10.1.2.12, 10.1.2.13, 10.1.2.14]

Three Decades of Caring for Those Most Vulnerable

The reach of Aetna Medicaid across 17 states and nearly three million members provides opportunities for comparative analyses of performance measures in varied economic markets, payment structures, and local environments. Aetna Better Health will also draw from Aetna Medicaid's 30 years of experience in root cause analysis and reengineering test trials for innovative pathways of care.

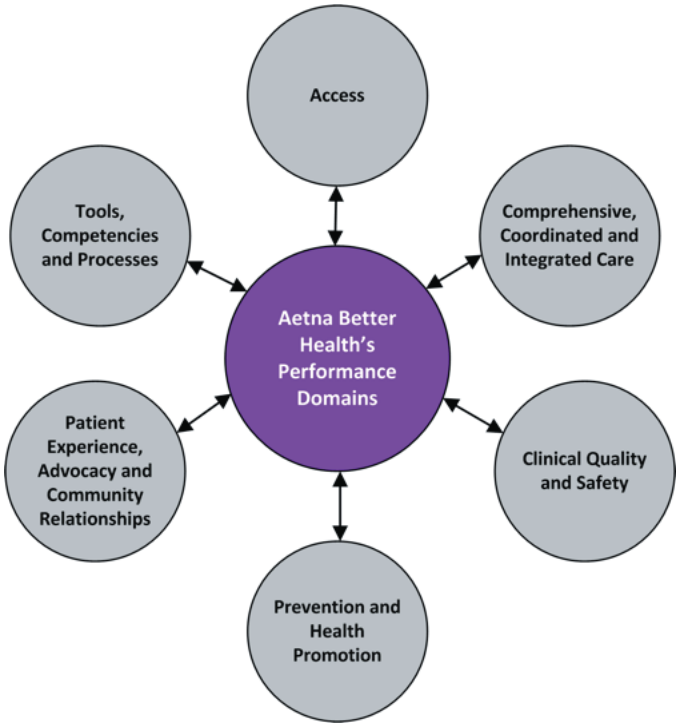
Performance measures for a comprehensive assessment of quality

Describe how you will utilize program data to support the development of the Quality Management and Improvement Work Plan.

Overall quality of care for an individual member or a subpopulation of members cannot be characterized or defined by a single measure or single data source. Aetna Better Health has developed a matrix of performance measures grouped in six domains as shown in Figure 10-3 below:

- **Access –** Identifying members who need care; facilitating access to and timeliness of appropriate care; assessing availability of care resources; assessing the integration of behavioral health and social service supports to address complex needs
- **Comprehensive, coordinated and integrated care –** Using evidence-based practices; developing tailored care plans; supporting members in managing their own care; maintaining continuity of care; integrating services through multidisciplinary teams
- **Clinical quality and safety –** Aligning treatment and clinical outcomes with standard safety and effectiveness goals; protecting members during care transitions; supporting shared decision-making regarding safety and member priorities for quality of life
- **Prevention and health promotion –** Aligning member outreach and services with national guidelines for preventive care; supporting members in choosing and maintaining healthy behaviors; supporting providers and multidisciplinary teams in clinical decision-making to improve delivery of preventive services
- **Patient experience, advocacy, and community relationships –** Proactively assessing member experiences to inform QI; integrating advocates and peer support; providing culturally appropriate care; paying attention to health literacy; supporting care processes in the context of strong community linkages; proactively assessing and correcting inequities
- **Tools, competencies, and processes –** Making best us of health information technology to improve communication between providers and members; drawing on diverse data sources to inform continuous quality improvement and reengineering of care processes; facilitating effective staff training and continuous development of competencies in providing exemplary care; assessing non-clinical and administrative processes for efficiency and efficacy

Figure 10-3: Six domains of performance measures for the comprehensive assessment of quality



Using these domains helps us select and develop the right QI projects and makes our annual quality work plan more effective and comprehensive. How we apply this framework depends on the problem. For example, we might apply it to a small and specific member demographic or diagnosis group—such as members who live in Muscatine County or members with serious mental illness—or to larger groups—such as all children ages 3 through 6 who are served in a single plan year. By examining measures in multiple domains, we improve the assessment of inequities in care for minority populations and for members with complex biopsychosocial needs.

Our QM/QI strategy will include continual measurement and monitoring to support timely detection of quality of care concerns and opportunities to improve the care received by our members. Appendix M provides our draft annual quality work plan.

Data resources support analysis of member and provider trends and outcomes

Our data management system will support our QM/QI and UM processes and programs and will support analysis of member and provider utilization trends and outcomes. System reports help us determine if quality improvement activities are meeting our defined objectives. Our reports and monitoring integrate data from multiple sources. Some of the data sources include, for example:

- **Claims data** helps us monitor whether members have received recommended services and screenings; is used as input to our Consolidated Outreach and Risk Evaluation (CORE) predictive model; helps us understand patterns of utilization of services and helps us identify over- and under-utilization of services; flags utilization that may indicate serious member concerns or non-compliance with recommended treatment; helps us detect patterns of fraud, waste, and abuse; and much more.
- **Pharmacy claims data** lets us know which medications the member is taking; allows us to look for gaps in refills or inappropriate patterns of prescribing of medication; and much more.
- **Member demographic and enrollment data** allows us to understand several aspects of member populations, including geographic distribution, family associations, culture, and much more.
- **Provider data** helps us identify provider distribution and adequacy of the provider network; demographic data for providers, including ethnicity and languages spoken; helps us match member needs to those providers best able to meet them; and much more.
- **Service authorization data** helps us understand service utilization patterns; identifies members who are repeat users of high-acuity services, such as the ED and inpatient services, so we can contact them, assess their needs, and determine whether they need care management; helps us evaluate the appropriateness of prior authorization requirements; helps us detect patterns of fraud, waste, and abuse; and much more.
- **Member and provider services call data** helps us monitor trends in issues. For example, patterns of provider calls about specific claim types might indicate problems in the configuration of the claims system or that we need to clarify instructions for billing certain types of services. Patterns of member calls about a particular provider's actions may indicate that the provider is not in compliance with contract requirements or is practicing inappropriately.

By combining data sets during analysis, we achieve more powerful results. For example:

- Using member, claims, and provider data, we can profile the performance of physicians, compare them against other physicians in the practice, HEDIS benchmarks and goals, and the plan as a whole. We can also tell each provider which members might be missing recommended screening or treatment services.
- Analyzing member claims over their membership in the plan and against recommended health checkup or treatment schedules, we can identify potential gaps in care and give information to providers to address those gaps. We can do the same with pharmacy data. If we see that a member originally filled a prescription for a chronic condition but has not regularly refilled the prescription, we can contact the member to educate them about the importance of complying with the instructions on the prescription and the need to regularly refill it.

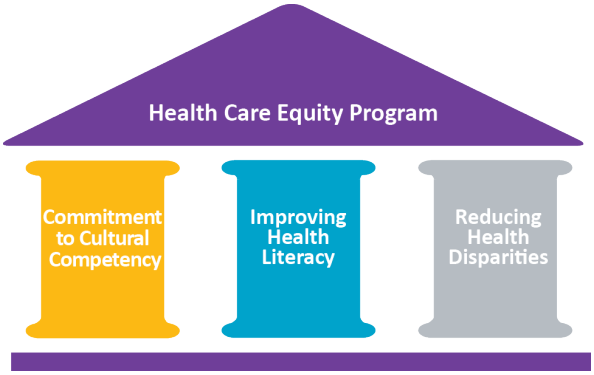
It is the way in which we combine data sets and analyze the combined data to look for relationships that brings power to what we can do in helping achieve the best outcomes for the member.

Drawing from performance data to promote health care equity

Aetna Medicaid is committed to reducing disparities for the underserved; our goal is to achieve health care equity for all members regardless of race, ethnicity, gender, age, socio-economic status, or special needs. Aetna Medicaid has established a national Health Care Equity (HCE) collaborative, which will support Aetna Better Health in developing local HCE QI initiatives. Aetna Better Health will identify an Executive Sponsor and Champion and will convene a HCE Response Team in Iowa.

Aetna Better Health's HCE Executive Sponsor, the Champion, and the HCE Response Team will collaborate with Aetna Medicaid to develop data reports and analyses to help identify disparities and inequities across our member population in Iowa. The team will generate reports through data analysis using CORE, Quality CORE, claims, and other data. Our QI programs will target the needs of populations for which we have identified disparities. Examples of HCE programs in development at the national level or in other Aetna Medicaid markets include:

- Asthma and chronic obstructive pulmonary disease (COPD) education and intervention (African American)
- Diabetes education and intervention (Hispanic)
- Behavioral health: managing disparities in access
- Minority women's health programs (African American, Hispanic, Refugee)
- Weight management (Hispanic, African American)
- End of life resources for special populations



We will also benefit from the ongoing development of Aetna Medicaid's national HCE effort through:

- Disparities reports to identify specific disparities (our goal is to review these quarterly)
- Support for engagement of community health workers or "promotoras" (lay Hispanic/Latino community members who receive specialized training to provide basic health education) in each market
- Resources to educate members and increase understanding, adherence, and access
- Resources to educate employees regarding market-specific cultures or cultural behaviors

See our response to Section 6.1.4, Question 1 for more information on our HCE approach.

ANNUAL POPULATION ASSESSMENT

We are committed to improving our members' health outcomes, enhancing their quality of life, and reducing racial, ethnic, and other cultural health disparities. Every year, the QM/QI Department will assess population changes, race, ethnicity, geographic distribution, language preferences, cultural diversity trends, disability, and changes in age distribution within the health plan's membership. We will collect data on member race, ethnicity, primary language, disability, and geography using several sources, such as:

- Member enrollment files
- Member health risk assessments
- The CAHPS®
- Medical records or automated encounter records of contracted practitioner organizations

- Direct contact interactions such as welcome calls
- Geographical access analysis of member distribution

The QM/QI Department will use the cultural characteristics of Iowa members identified from these data sources to create member-specific interventions and **we also include in the assessment outcomes of our CM and DM programs and enhance these programs as needed in relation to our population analysis**. We also collect information about provider race, ethnicity, and languages spoken on credentialing and network enrollment applications to help us in better matching cultural and language needs of members to appropriate providers.

Attachment 5 – Section 10.1, Question 3 [SOW 10.1.1, 10.1.2.1, 10.1.2.10, 10.1.2.11, 10.1.2.12, 10.1.2.13, 10.1.2.14, 10.1.2.18]

Detail your experience in and strategies for improving quality indicators, including HEDIS measures, CAHPS measures and satisfaction surveys. Describe how you will apply that experience in Iowa.

Monitoring and assessing quality

The Aetna Better Health QM/QI Department will monitor and measure the current state of quality using metrics such as HEDIS, CAHPS®, provider satisfaction, and member satisfaction with care management. We will incorporate additional measures defined by Iowa's MHDS Redesign, the Iowa Chronic Care Health Home, Iowa Integrated Health Homes, and the Iowa Medical Home Bonus Program as defined through the SIM and use of the Value Index Score.

EPSDT drives improvements in HEDIS scoring, but they have different measurement schedules. We have specific education about these for PCPs. We help them understand the differences and meet the requirements in the right timelines, so we can achieve meaningful results for members.

We will use measurement results to identify areas for improvement, set specific performance goals for the upcoming year, and develop an action plan for achieving those goals. The QM/QI Department will monitor performance and track data trends using the following processes:

- Performance related to measure sets defined by NCQA and the Agency
- Evaluation of rolling 12-month rates to identify negative trends and take timely corrective action
- Application of health risk assessment and utilization data through predictive modeling to identify quality-of-care concerns and opportunities to improve for enhancing success
- Review of data collection processes to confirm that the information gathered is accurate

Our proactive approach will help improve the quality of our services and achieve positive outcomes against key measures. We will analyze and distribute measurement results throughout the QM/QI committees, which will advise our team and recommend appropriate actions.

Strategies for improving quality indicators

We will use Iowa population health data and the Agency's quality initiatives to select areas of focus.

DEMONSTRATED SUCCESS: IMPROVING PRENATAL CARE

To improve performance in the HEDIS measure Prenatal and Postpartum Care Timeliness of Prenatal Care, the Aetna Medicaid health plan in Texas has implemented several interventions, including:

- **Member newsletters** – Includes articles describing healthy pregnancies and the importance of ongoing care

- **Care Management program** – Contacts members and educates them on community resources available to them, such as Women, Infants, and Children program (WIC), birthing classes, appointment and transportation program assistance, and other community-based programs to help new moms
- **Bilingual "fotonovela"** – Photo-rich short stories integrated into the Care Management program for pregnant members to teach them about the need for early PCP visits for newborn infants
- **Member Outreach Center** – Contacts pregnant members to conduct an initial health screening to identify any high-risk factors for pregnant members; results are shared with the Care Management Department
- **Text4Baby program** – A free mobile health service that provides text messages three times a week; these messages are customized and timed for delivery based on the baby's due date or on the age of the child up to their first birthday; the messages cover topics such as nutrition, immunizations, and the recommended timeline of well-child visits
- **Provider newsletters** – Discuss the importance of early and ongoing prenatal care, as well as address issues regarding the proper coding of claims

As a result of these interventions, we have observed an improvement in this HEDIS measure from 64.62% in 2010 to 83.81% in 2012.

SMART TEXTING REMINDERS FOR MEMBERS

We will offer smart texting notifications to remind our members to complete screenings and activities that positively impact HEDIS measures. Currently, Aetna Medicaid plans offer this feature in Arizona, Maryland, and Texas.

QUALITY IMPROVEMENT PROJECTS (QIPS)

We will implement QIPs that focus on clinical and non-clinical areas of interest. The QM/QI Department will prepare QIP proposals for review and approval by the CEO, CMO, the QM/UM Committee, and the QMOC. We will select QIPs and areas of topics based on:

- Agency contractual requirements
- Impact on a significant portion of our members, including special health care needs and high-volume or high-risk conditions
- Ability to achieve and sustain improvements in members' health, functional status, or satisfaction
- Objective performance indicators, as defined by the Agency and NCQA

Each QIP will be designed to improve quality; the QIP will specify how we will evaluate effectiveness and how we will plan, initiate, and sustain improvement. QIPs will include performance indicators that are objective, measurable, and based on national benchmarks or historical data. We will make certain that each QIP complies with 42 CFR §438.240 and CMS requirements, contractual or regulatory requirements, and nationally recognized accreditation standards.

EVALUATING PROGRESS

Aetna Better Health will use the Plan-Do-Study-Act (PDSA) method to assess our outcomes and develop and implement interventions to improve performance. PDSA is a standard quality management tool for managing quality improvement through an iterative problem-solving approach. It provides the framework for developing and implementing interventions through the following steps:

- **Plan** – We identify an opportunity, and plan for improvement.
- **Do** – We test the theory for improvement by carrying out the plan we developed.

- **Study** – The team uses the data gathered to analyze results of test.
- **Act** – Based on what we've learned from studying the test, we refine our processes based on whether the test was successful.

We will continue iterative PDSA cycles until we achieve the preferred result. Once we improve a process or system, we will test it on a wider scale and incorporate the successful intervention as part of our ongoing processes to improve performance.

A collaborative approach to improving performance

We will capitalize on the knowledge and experience of Aetna Medicaid by participating in a bi-monthly Quality Management collaborative. This collaborative will include members of the Aetna Medicaid QM/QI Department and QM/QI staff members of other Aetna Medicaid health plans. The collaborative provides a forum to share information about quality activities, encourages collaboration and learning, and provides an opportunity to share best practices.

Predictive modeling to evaluate risk of member noncompliance

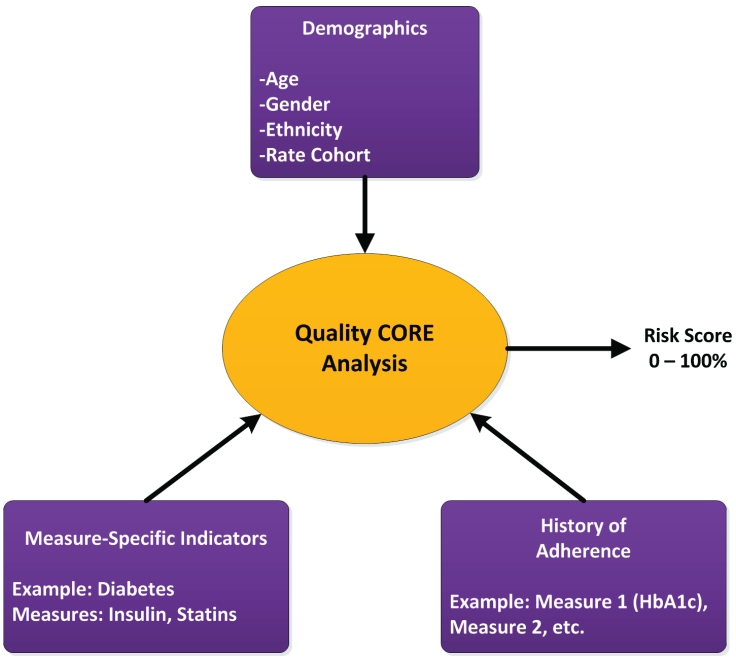
We will use the Aetna Medicaid Quality CORE program to assess member compliance with recommended preventive services. Quality CORE identifies the risk of member non-adherence with identified quality measures by giving us a 360-degree view of the member's health status and gaps in care. It enhances and extends our CORE predictive model by identifying members who need follow-up; it also helps us organize and customize that follow-up based on the identified risks for those members.

Using HEDIS measures, Quality CORE applies measure-specific predictive models to assess the member's risk for being non-adherent for a particular measure. The models use a tiered approach that focuses on key indicators in three areas (see Figure 10-4):

- Demographics (age, gender, ethnicity, Medicaid rate group)
- Past adherence history (member's past history of adherence for a measure)
- Measure-specific indicators (for example, pharmacy adherence for insulin and statins for diabetic care)

The resulting risk score is a probability between 0 and 100%. The higher the score, the more likely the member is to be non-adherent for the recommended health service in a given HEDIS measure. The risk scores will allow us to identify subsets of the member population according to level of risk. We can then target each subset for outreach. For example, this outreach might range from mailings or automated reminders for low-risk groups to direct contact with members for high-risk groups.

Figure 10-4: Quality CORE analyzes member risk for missed services



Quality CORE produces outreach lists that contain the contact information for the member and the member's assigned PCP. Each outreach list will show additional measures for which a member may not be adherent and other indicators that may prompt us to connect a member with appropriate care.

We calculate risk scores for HEDIS measures, such as Comprehensive Diabetes Care or Adolescent Well Care. Reports show trends in adherence rates month-over-month and in comparison to the prior year. Quality CORE reports also track adherence rates against our annual performance goals.

Other Quality CORE reports show member adherence rates by individual practitioner and by provider groups. These reports show what proportion of a practitioner or provider group panel is at higher versus lower risk for non-adherence for a specific measure. We will use this information to help these practitioners and groups develop and implement improvements.

Our QM staff will examine the Quality CORE data each month to identify members for outreach and then select the most appropriate interventions. We will involve both providers and members and will focus on the following objectives:

- Improve members' overall health through preventive care
- Assess the relative effectiveness of incentive-type interventions in effecting change
- Evaluate optimal intervention support levels
- Identify the types of support we need to offer each risk group

Accountability for access and quality of care through HEDIS reporting

We will report on the required HEDIS measures for quality improvement, tracking year-to-year performance, and to compare our performance to other plans and to national or regional benchmarks. HEDIS is also an essential part of measuring provider performance for our VBP programs. To develop QI strategies and QIPs, we will examine provider HEDIS scores and trends and look for opportunities where we can support providers in moving to the 75th and 90th percentile national benchmarks. Table 10-4 shows recent HEDIS performance data for Aetna Medicaid plans for measures relevant to Iowa's state quality initiatives. See Appendix V for a complete report of HEDIS data.

Table 10-4: 2014 HEDIS performance of Aetna Medicaid plans-CONFIDENTIAL

CONFIDENTIAL				

- CONFIDENTIAL				

Evaluating member satisfaction through CAHPS®

CAHPS® survey results will be an integral part of our QM/QI program. The QM/QI team will analyze and disseminate CAHPS® results internally through department communication protocols and the QM/QI committee structure. We will apply thresholds when analyzing the mean scores and actual CAHPS® rates; **any scores below the 75th percentile are targeted for in-depth analysis, action, and improvement.** Regardless of the scores, we will conduct in-depth analyses of ratings and identify opportunities for improvement. We track and trend results against previous years, as well as against NCQA and other industry benchmarks to measure our progress. Based upon review of the survey results, internal stakeholders will provide input and suggestions through department meetings and formal QM/QI committees. The Service Improvement Committee (SIC) advises and makes recommendations to the QMOC about member and provider operational issues. The SIC will be responsible for reviewing survey results and identifying the appropriate workgroup or

There were 4 plans with Child CAHPS survey results in the 75th percentile for Rating of the Health Plan and Getting Care Quickly, and 3 plans at the 90th percentile for Getting Care Quickly.

For the Adult CAHPS survey results, there were 5 plans at the 75th percentile for Rating of the Personal Doctor and 4 plans at the 75th percentile for Getting Needed Care.

committee to develop a QIP to remediate each performance issue. Table 10-5 summarizes CAHPS® performance data in Aetna Medicaid plans.

Table 10-5: CAHPS® 2014 performance for Aetna Medicaid plans-CONFIDENTIAL

[redacted]	[redacted]			[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]	[redacted]	
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Attachment 5 – Section 10.1, Question 4 [SOW 10.1, 10.1.2.7, 10.1.2.16]

Describe your experience and strategies in working with network providers to improve outcomes.

Aetna Better Health will work with providers in several ways to improve health outcomes. These methods include the following:

- **Provider contracts.** Our contracts with participating providers set expectations for the provider in compliance with plan policies and procedures, including those for UM, QM, and Care Management protocols and information exchange. Contracts let the provider know what we expect from them in caring for the member, and what we will do to help facilitate that care.
- **Provider education.** We educate providers using various methods, including the Provider Manual, initial provider orientation, scheduled training webinars, provider educational forums, and scheduled in-service and ad hoc provider office visits. Education further specifies the details of policies and procedures outline in the contract, addresses provider questions and typical situations, and helps guide the provider and office staff to the right actions and the right resources to help serve the member.
- **Clinical practice guidelines.** Aetna Medicaid uses and makes available evidence-based preventive health guidelines and clinical practice guidelines. We developed or have adopted these guidelines with input from the appropriate specialties; these guidelines are reviewed and approved by the QM/UM Committee. We also use and make available Aetna Clinical Policy Bulletins regarding the

experimental and investigational status and medical necessity of medical technologies and other services. See our response to Section 10.1 Question 1.

- **Utilization management (UM).** Our UM processes and resources help provide guidance to network providers regarding medical necessity of services. Providers can always contact our Medical Directors or CMO for a collegial discussion on the most appropriate clinical approach for a given member's situation.
- **Practitioner profiling.** Profiles will identify trends related to cost, quality, and utilization while holding providers accountable for delivering care. Profiles will summarize member compliance with health and wellness screening as defined by HEDIS measures. This summary helps providers identify members who need care and services so they can contact members and schedule appointments. Profiles help us:
  - Assess PCP performance; support patient-centered medical homes (PCMHs) and similar models
  - Monitor pay for quality and total cost of care models
  - Support other practitioner quality and VBP efforts
- **Information resources.** Our provider portal allows providers to access member information at the point of care, including information on care gaps and services needed. The portal offers access to many resources, including the provider manual, educational information, clinical practice guidelines, newsletters, care plans, provider profiles, and others.
- **Value-Based Purchasing.** Aetna Medicaid offers a standard package of progressive payment arrangements called Value-Based Purchasing (VBP) in all of its markets. The intent of the VBP model is to move providers from the traditional fee-for-service model to progressive Pay-for-Quality (P4Q), Pay-for-Performance (P4P), Patient-Centered Medical Home (PCMH) and advanced risk arrangements that reward providers for delivering high quality care and achieving the triple aim. See our response to Section 10.3, Question 1, which explains our VBP program.

Attachment 5 – Section 10.1, Question 5 [SOW 10.1.3]

Outline the proposed composition of your Quality Management and Improvement Committee, and demonstrate how the composition is interdisciplinary and appropriately represented to support the goals and objectives of the Quality Management and Improvement Committee.

QMOC provides executive oversight of the QM/QI plan and integrates QM/QI activities throughout the health plan, delegated organizations, and provider network. Activities include the annual QM/QI program description, annual and prospective five-year work plans, and annual QM/QI evaluation, as well as UM, Case Management, and Disease Management plans, work plans, and program evaluations. Table 10-6 describes the QMOC and primary subcommittee composition and tasks.

Table 10-6: Aetna Better Health QM/QI Committee structure

Committee	Authority	Membership (interdisciplinary)	Meeting Interval
Quality Management Oversight Committee (QMOC)	• Integrate quality management and improvement activities throughout the health plan and the provider network • Provide executive oversight of QM/QI and make recommendations to the Board of Directors about quality management and improvement activities	• CEO (chairperson) • CMO • Chief Operating Officer (COO) • Chief Financial Officer (CFO) • Behavioral Health Medical Director • QM/QI Director • Medical Management Director • Health Care Equity Director • Director or Manager from other functional areas within Aetna Better Health • Member advocate representative(s) • Agency representative	At least six times a year: the Board of Directors will receive recorded minutes of all meetings for review, comment, and approval
QM/UM Committee	• Serve as Aetna Better Health's UM Committee • Advise and make recommendations to the CMO about the quality of care and service provided to members, including oversight and maintenance of the QM/QI and UM program • Integrate with other functional units of the health plan as appropriate and support the QM/QI program • Review and monitor UM activities	• CMO (chairperson) • Representative network providers, including PCPs, medical homes, specialists, dentists, behavioral health • Behavioral Health Medical Director • LTSS Director • QM/QI Director • Medical Management Director • Health Care Equity Director • Support staff as requested	Monthly: QMOC and the Board of Directors will receive recorded minutes; Agency can receive minutes upon request
Delegation Committee (DSC)	Advise and make recommendations to the QMOC about delegated relationships Note: We do not delegate QM/QI activities. We may delegate limited medical management activities.	• Compliance Director (chairperson) • COO or designee • Quality Management Director • Medical Management Director • Representatives from Member Services, Provider Services and Grievance Departments • Other selected staff or departments	At least quarterly: QMOC and Board of Directors will receive summary reports

Committee	Authority	Membership (interdisciplinary)	Meeting Interval
Aetna Credentialing and Performance Committee (CPC)	• Decision-making authority for credentialing and recredentialing individual providers who deliver services to members • Conduct professional review activities involving the providers whose professional competence or conduct adversely affects, or could adversely affect, the health or welfare of members	• Aetna Regional Medical Director (facilitator) • Representatives from a range of participating providers in specialties that include primary care and high-volume specialists. Other specialty providers may be included as necessary for peer review • Behavioral health providers including a psychiatrist, a psychologist and a masters level behavioral health clinician	At least every 45 days: The QMOC and Board of Directors will receive summaries of committee minutes.
Aetna Quality Oversight Committee (QOC)	• Conduct the credentialing and recredentialing of facilities, organizational providers, and vendors • Review potential quality of care issues and complaints of facilities, organizational providers, and vendor	• Aetna Regional Head of Health Care Delivery or designee (chairperson) • Representatives from Network Services, Member Services, Program Integrity (Compliance), Medical Management	At least 10 times a year: The QMOC and Board of Directors will receive summary reports
Pharmacy and Therapeutics Committee (P&T)	• Advise and make recommendations to the QMOC and CMO regarding our pharmacy program including the development of the formulary and the Preferred Drug List (PDL) • Consider products in categories recommended for consideration for inclusion or exclusion on the health plan's formulary or PDL	• Aetna Medicaid Pharmacy Director (chairperson) • CMO • Behavioral Health Medical Director • Representatives from the Pharmacy Benefits Manager • Representatives from Medical Management and Provider Services department • Network providers including physicians, pharmacists, dentists, behavioral health specialists and other specialists	Quarterly: The QMOC and Board of Directors will receive minutes and summary reports
Member Advisory Committee (MAC)	• Promote collaboration to enhance the service delivery system in local communities while maintaining member focus and allow participation in providing input on policy and programs	• COO (chairperson) • Member Services member • Aetna Better Health staff • Quality Management representative • Includes statewide broad representation of members, families, member advocacy groups, and providers that reflect the populations and communities served • Members, families, and member advocacy groups will make up at least 50% of the membership	Quarterly: The QMOC or SIC will receive minutes and reports for review

Committee	Authority	Membership (interdisciplinary)	Meeting Interval
Service Improvement Committee (SIC)	• Advise and make recommendations to the QMOC and Aetna Better Health management about customer (member and provider) issues	• COO (chairperson) • Medical Director/CMO or designee • Health Care Equity Director • Representatives from Member Services, Provider Services, Medical Management, Quality Management, and Grievance and Appeals Departments • Other selected staff as required	Quarterly: The QMOC and Board of Directors will receive summary reports
Compliance Committee (CC) aka Program Integrity Committee	• Review, monitor, and assess the effectiveness of our compliance plan. • The Manager of Compliance and the Compliance Committee have the responsibility and authority for carrying out the provisions of the compliance program.	• Manager of Compliance (chairperson) • CEO • COO • CMO • Medical Management Director • QM/QI Director • Member Services Manager • Grievance System Manager • Performance/Quality Improvement Coordinators (non-voting) • Provider Services Manager (non-voting) • Behavioral Health Coordinator (non-voting)	At least quarterly: The QMOC and Board of Directors will receive minutes and summary reports
Policy Committee (PC)	• Forum for the consistent development, implementation, approval, and communication of all our policies and procedures • Maintain written guidelines for developing, reviewing, and approving all policies and procedures • Review all policies and procedures at least annually to verify that the health plan's written policies reflect current practices	• Compliance Manager (chairperson) • Grievance System Manager • Medical Management Manager • Quality Management Coordinator • Provider Services Manager • Representative from Finance • Administrative support (non-voting)	At least monthly: The QMOC will receive minutes for review and acceptance

10.2 State quality initiatives [SOW 10.2.1, 10.2.2]

Aetna Better Health will align our plans and goals with those identified by the Agency and the external quality review organization (EQRO). This alignment includes focusing on programs to achieve quality outcomes and timely access to health care services. The EQRO review process will be an integral component of our QM/QI program. It provides the framework by which we will monitor and strengthen all functional processes of the organization, provide a measurement of performance in service and quality of care, emphasize team work, take a multi-organizational approach to quality improvement, and focus on state and federal regulatory compliance.

The Board of Directors has ultimate accountability for the QM/QI program and EQRO review; however, the Board of Directors may delegate responsibility for the QM Program and the EQRO process to the QMOC. Several other committees will have EQRO oversight responsibility. These include Compliance, QM/UM, and Service Improvement. Implementing recommendations of the EQRO is a collaborative process involving these committees, the Aetna Better Health team, the Agency, and the EQRO.

Aetna Better Health is committed to helping the Agency achieve the goals of health transformation defined in the Healthiest State Initiative, Mental Health and Disability Services Redesign, SAMSHA Substance Abuse Prevention and Treatment block grant, and the SIM. Several of the programs we plan to use will affect more than one Agency initiative; it is likely that other participating plans and state agencies will be undertaking similar tasks. **Thus, coordination among stakeholders will be critical to using all resources effectively to achieve the greatest improvement in outcomes.** We propose that the Agency, health plans, and selected stakeholders convene a planning session early in the implementation of the Contract. We suggest an agenda for that meeting that would cover the following topics:

- Overview of the current "state of the Agency" regarding Iowa health and areas of concern
- Overview of each of the major Agency initiatives
- Overview of actions either planned or underway by Iowa agencies, contractors, or community organizations
- Presentation by each participating health plan of proposed initiatives and actions
- Defined work groups to examine areas in which different initiatives and actions duplicate, reinforce, or complement each other
- Defined follow-up meetings, work sessions, and informational sessions to coordinate the efforts of the Agency and the health plans

We would propose that the Agency, or another relevant Iowa agency, assign someone to lead this session and serve as the overall coordinator for the work groups. Each health plan and stakeholder, including Aetna Better Health, would assign a representative to participate. Through this planning session and follow-up sessions by work groups, we can help achieve the best for Iowa, together, while preserving the unique strengths and innovations offered by each stakeholder in the system.

Attachment 5 – Section 10.2, Question 1 [SOW 10.2.3]

Describe how you propose to work with the Healthiest State Initiative.

The Iowa Healthiest State Initiative is a public endeavor to encourage and inspire communities throughout the state to improve their health and happiness. To measure progress, Iowa is using the Gallup-Healthways Well-Being Index®, which is based on six sub-indices that correlate with state-level measures on healthy behaviors, access to care, income or employment, education, and community

infrastructure. By improving access to appropriate care and encouraging healthy behaviors, we will contribute to the Healthiest State Initiative in several ways. Refer to Table 10-7.

Table 10-7: Aetna Better Health strategies for contributing to the Healthiest State Initiative- **CONFIDENTIAL**

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Attachment 5 – Section 10.2, Question 2 [SOW 10.2.4]

Describe how you propose to work with the Mental Health and Disability Services Redesign.

We have studied the MHDS Redesign recommendations for best practice services within the framework of continuous quality improvement. Table 10-8 summarizes our strategies:

Table 10-8: [redacted] **CONFIDENTIAL**

Domain: Outcome	Aetna Better Health strategies for improving care
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[1] Up to three indices with highest correlations are listed; list includes only those correlates significant at the 0.01 level

Domain: Outcome	Aetna Better Health strategies for improving care
Life in the community: *Members have* [redacted]	[redacted]
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Attachment 5 – Section 10.2, Question 3 [SOW 10.2.5]-CONFIDENTIAL

Propose strategies to incorporate the Value Index Score (VIS) as a tool to drive system transformation, and other strategies to support the State Innovation Model (SIM).

Aetna Medicaid supports Governor Branstad's vision to innovate and develop next-generation healthcare payment and delivery models through Iowa's SIM grant. Aetna Inc. has been engaged with SIM grants and multi-payer demonstrations in various states including Arizona, Connecticut, Delaware, Maine, New York, Ohio, Pennsylvania, Maryland, Tennessee, and Utah. Aetna Medicaid health plans have been selected to participate in dual-eligible programs in five markets: Arizona, Illinois, Michigan, New York, and Ohio.

Aetna Inc. has publicly committed that 75% of the company's network contracts will be tied to value-based arrangements by 2020. Aetna Better Health commits to having 50% of our Iowa members with providers who are under value-based arrangements by 2018, exceeding the RFP requirements.

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With the SIM grant model proposed and connectivity being established throughout the state with Iowa's Health Information Network, our Community Provider Interface will allow providers to connect to a common platform and dashboard. The approach connects the entire care teams to maximize coordination of care, minimize duplication of services, and facilitate collaboration. We will offer a comprehensive health technology package that will feature mobile and telehealth technologies to make certain members living in rural or underserved areas can manage their own care and have access to the care they need, when they need it.

The SIM grant offers tremendous opportunities for payers to work with providers to develop new best practice models around care coordination, transitions of care, integrated physical and behavioral health, health promotion, prevention, and wellness. These models will promote deeper engagement with our members and their families to create a delivery system that is outcomes-focused and patient-centered. Our ultimate goal is to empower our members to be active participants in their own care—making informed decisions with an engaged team of providers that has the data, skills, and competencies to help members achieve success. By bringing complementary tools, care management support, and aligned incentives, we will work with providers to create best practice care coordination approaches and together realize Iowa's Triple Aim.

Detailed descriptions of the VBP program and Aetna Medicaid's next-generation integrated care model are provided below, in Section 10.3 in the response to Question 1.

Attachment 5 – Section 10.2, Question 4 [SOW 10.2.6]

Describe your experience in supporting a State authority in meeting the requirements of the Department of Health and Human Services Substance Abuse and Mental Health Services Administration Substance Abuse Prevention and Treatment Block Grant.

Our Experience

The plan that Aetna Medicaid manages in Arizona has been managing an extensive SAMHSA block grant since April of 2014. A small team of staff conduct general management, oversight, and reporting for both Substance Use Disorders prevention and treatment. The team conducts provider reporting; provider monitoring visits; and financial analysis and reporting; they provide quarterly reporting to regulators on programmatic and financial results.

SUBSTANCE USE DISORDERS PREVENTION

Under the grant, we collaborate and administer funding for community coalitions for Substance Use Disorders prevention using various strategies. In these strategies, we use quantitative and qualitative data to comprehensively assess community needs and to develop prevention initiatives. Our initiatives have reduced youth substance use in those communities where we have provided coalition funding.

Coalitions funded by the grant include the COPE Coalition in Glendale, AZ; the Chandler Coalition on Youth Substance Use Disorders; the LGBTQ Consortium; the Maricopa Behavioral Health Advocacy Coalition; the Mesa Prevention Alliance; the North Phoenix Prevention Alliance; the Urban Indian Coalition of Arizona; the South Mountain Works Coalition; the Scottsdale Neighborhoods in Action Coalition; the Help Enrich African American Lives Coalition; the Tempe Coalition; and the Way Out West Coalition.

Initiatives for prevention have included radio and movie theater public service announcements; placement of community stickers and posters; tables at community events; community education presentations; training at town hall meetings; social media outreach; life skills workshops; and others.

The plan also received a grant to enhance our prevention system to address prescription drug misuse and abuse prevention (Harold Rogers federal grant) in partnership with the Arizona Criminal Justice Commission (ACJC) and the Maricopa County Department of Public Health. The plan has been recognized nationally for the work Arizona is doing in this area at a systems level. As the next step in the evolution of this program, we are working on a comprehensive strategic plan that crosses systems, including law enforcement, prescribers, public health, pharmacies, schools, community members, etc.

SUBSTANCE USE DISORDERS TREATMENT

We provide Substance Use Disorders treatment services for non-Medicaid individuals in order of the priorities specified by SAMHSA. Priority populations including treatment for pregnant and parenting women. Grant funding also supports medication-assisted treatment (e.g., methadone, suboxone); detoxification services in a subacute or outpatient settings (as grant funding cannot be used for inpatient acute care); residential and intensive outpatient treatment. Our actions have helped to reduce 30-day substance use and incarceration and improved employment and the availability of stable housing.

Our Approach for Iowa

Iowa's SAMHSA Substance Abuse Prevention and Treatment Block Grant covers a broad scope of activities, as follows:

- **Addictions Service System Transition**: To advance an integrated resiliency- and recovery-oriented system of care for addictive disorders
- **Complex Capacity Development**: To build the capacity of prevention organizations and treatment programs to meet the complex needs of their communities, clients, and families
- **Enhancement of Surveillance Expertise**
- **Outreach and Services for Substance Using Pregnant Women and Women with Dependent Children**
- **Outreach and Services for Persons Who are Intravenous Drug Users**
- **Outreach and Services for Individuals with Tuberculosis**

Aetna Better Health intends to contribute to positive improvements that align with the SAMHSA Block Grant in the following ways:

- Improve integration of behavioral health and Substance Use Disorders screening and referral for counseling in primary care, to improve early identification of concerns and facilitate access to appropriate treatment and supports
- Improve reach of ICM and use of HCBS, to improve coordination of care for persons with serious mental illness, substance use disorders, or co-occurring disorders
- Improve early identification and enrollment of members in Pregnancy Case Management, to improve screening for behavioral health and Substance Use Disorders concerns and referral to appropriate supports, including our Neonatal Abstinence Program

Attachment 5 – Section 10.2, Question 5 [SOW 10.2.3 through 10.2.6]

Submit a project plan describing your specific approach and timetable for addressing this section.

The essence of the Healthiest State Initiative and State Innovation Model (SIM) will be fully integrated into ABH of IA QM/QI activities and member incentive and provider programs.

Please see Appendix M for Quality Management Plan and State Innovation Model Plan, as well as a project plan for implementing Aetna Better Health's strategies for aligning programs and QM/QI activities with Iowa's State Quality initiatives and SIM.

10.3 Incentive programs

Attachment 5 – Section 10.3, Question 1 [SOW 10.1.2.16, 10.3.2]-

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Describe your proposed provider incentive programs.

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Attachment 5 – Section 10.3, Question 2 [SOW 10.3.3]-CONFIDENTIAL

Describe your proposed member incentive programs.

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Committed to Health Care Transformation in Iowa

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10.4 Critical incidents

Attachment 5 – Section 10.4, Question 1 [SOW 10.4.1, 10.4.2]

Describe your critical incident reporting and management system.

Our QM/QI Department will investigate critical incidents; potential quality of care (PQoC) concerns; and reports of abuse, neglect, and exploitation of children and incapacitated or vulnerable adults, regardless of provider network participation. We will require internal staff and network providers to:

- Report and respond to critical incidents; PQoC; and reports of abuse, neglect, and exploitation
- Document incidents, concerns, and reports
- Cooperate with any investigation conducted by Aetna Better Health or an outside agency

We will comply with the guidelines in the Iowa Medicaid Enterprise Incident Management Provider Access System (IMPA), Form 470-4698 Critical Incident Report Users Guide. We will integrate the Iowa Medicaid Enterprise requirements into current Aetna Medicaid policies for Reporting of Potential Quality of Care (PQoC) concerns and the Reporting of Abuse, Neglect, and Exploitation of Children and Incapacitated or Vulnerable Adults.

Oversight

Our CMO will oversee the investigation and reporting processes. The QM/QI Department will track all incidents and concerns to identify potential trends across our network and will collaborate with the Agency on tracking and investigation of incidents and concerns through the IMPA system. Reports,

including identification of any trends and recommendations for correction actions, where necessary, will be presented to the QM/UM Committee quarterly. Staff who have contact with members or providers will complete training on how to refer suspected issues to the QM/QI Department and to state agencies. We will provide this training during new hire orientations and at least annually. The QM/QI Department will provide quarterly updates to the SIC on the volumes of referrals by department and will make recommendations for ongoing training needs.

Assessment and reporting

We will use the IMPA and Form 470-4698, as prescribed in the User's Guide, to identify and report critical incidents. Our integrated quality review process will confirm that issues involving critical incidents, quality of care or service, safety, complaints, or other areas of dissatisfaction receive expeditious and appropriate review. Any employee who perceives a potential quality, risk management, or safety issue must refer it to the QM/QI Department. A referral may begin in any department, including Care Management, Provider Services, Utilization Management, Compliance, Grievance and Appeal, or Member Services. That department will document the issue and forward it to the QM/QI Department for evaluation. QM/QI Nurse Consultants may review and assign a different functional area within the organization to review and address the needs (for example, grievance and appeals). We will also require contracted practitioners and providers to report, respond to, and document critical incidents.

Indicators used to identify critical incidents, potential quality, risk management, and safety issues are specific to Aetna Better Health and approved by the QMOC. These indicators are outlined in several of our policies including: Critical Incident Reporting and Management, Provider Preventable Conditions, Review of Potential Quality of Care Concerns and Reporting of Suspected Occurrences of Abuse, Neglect, or Exploitation of Children or Incapacitated or Vulnerable Adults.

PQOC CONCERNS

A PQoC is a concern raised to the health plan by anyone inside or outside the plan that requires investigation as to whether the competence or professional conduct of an individual Aetna network practitioner, facility, or ancillary providers adversely effects, or could adversely affect, the health or welfare of a member. Aetna Medicaid has a national policy that informs plan-level policies and:

- Provides criteria by which any Aetna associate can identify PQoC concerns
- Defines a systematic process to facilitate the submission of PQoC concerns to designated Aetna Medicaid staff
- Defines criteria and processes to evaluate and investigate PQoCs
- Identifies the quality of care events and activities which demonstrate that a provider's continued participation in a network presents a risk to members
- Identifies trends that can be a catalyst for patient safety activity

SUSPECTED ABUSE, NEGLECT, OR EXPLOITATION OF CHILDREN OR INCAPACITATED OR VULNERABLE ADULTS

Staff must report suspected occurrences of abuse, neglect, or exploitation of children or incapacitated or vulnerable adults to applicable authorities as required by Iowa law. Any report to state authorities must follow state requirements for such reporting. We will develop an Iowa-specific policy to define:

- Documentation of incidents
- Notification to Compliance and QM/QI Departments

- Appropriate disposition and action
- Appropriate response to external requests for information

Attachment 5 – Section 10.4, Question 2 [SOW 10.4.3]

Describe strategies for training staff and network providers on critical incident policies and procedures.

Staff Training

We will train all Aetna Better Health staff on the policies and procedures covering recognition and reporting of critical incidents and the triggers for identifying and reporting events that involve our members. New hires must participate in an on-demand electronic training course that explains how to identify a PQoC concern and how to refer it to the QM/QI Department. We also explain the required timeframe for reporting a critical incident per the IMPA and User Guidelines. Annually, the QM/QI Department will conduct in-service training with each health plan department. We provide a trigger list to all staff; it includes examples showing the kinds of incidents that could indicate substandard care or inappropriate professional performance, competence, or conduct. Examples include:

- "Never" events — Misdiagnosis or missed diagnosis with serious outcome or disability; infant discharge to wrong person
- Surgery-related events — Complication of surgery, unplanned return to the operating room, complication with anesthesia, or unexpected admission post-surgery
- Mental health or substance use treatment events — Elopement from an inpatient mental health unit or self-inflicted injury during inpatient or outpatient treatment
- Delay of care or service — A delay in accessing care or service that has a negative effect on a health problem, worsened a condition or required emergency treatment
- Member-reported events — Abnormal diagnostic findings allegedly not addressed by practitioner or other instances where the member alleges adverse effect on health or welfare

Provider Training

Our Provider Manual will explain how to identify and report critical incidents; PQoC concerns; and suspected occurrences of abuse, neglect, or exploitation of children or incapacitated or vulnerable adults. We will develop training for providers to recognize and report potential critical incidents. This information will be in our Provider Manual, presentations, and handouts. Providers must report a critical incident through the IMPA and to Aetna Better Health within 24 hours of identification.

Providers also will learn about their obligation to take immediate steps to prevent further harm to any and all members when they discover a critical incident. Training addresses the following topics:

- Unexpected death of a member
- Missing person or unable to contact
- Suspected or evidenced physical or mental abuse (including seclusion and restrains, both physical and chemical)
- Theft with law enforcement involvement
- Law enforcement contact
- Severe injury or fall resulting in the need for medical treatment
- Medical or psychiatric emergency, including suicide attempt
- Medication error

- Inappropriate or unprofessional conduct by a provider involving the member
- Sexual abuse or suspected sexual abuse
- Abuse and neglect, including self-neglect, or suspected abuse and neglect

Provider Services Representatives will conduct office visits at PCP and LTSS offices, where they will educate the office staff about the requirements for reporting critical incidents. Representatives reinforce this information during subsequent office visits and in periodic provider education forums.

Attachment 5 – Section 10.4, Question 3 [SOW 10.4.4]

Describe processes for implementing corrective action when a provider is out of compliance with critical incident reporting.

Our contracts with providers will require them to identify and report critical incidents. Our policies and procedures specify a formal peer review and corrective action process used when a provider is out of compliance. Either the Aetna Credentialing and Performance Committee (CPC) or the Aetna National Quality Oversight Committee (NQOC) conducts formal peer review depending on the type of provider involved. These committees will make a decision and initiate follow-up actions based on these investigations and will also make credentialing and recredentialing decisions, including ongoing monitoring and off-cycle review. The Aetna CPC and Aetna NQOC have decision-making authority and may initiate professional review activities regarding the professional competence or conduct of providers whose conduct could adversely affect the health or welfare of members. Upon review of reported incidents, these committees may take the following actions:

- Request additional information
- Recommend that the Aetna Better Health CMO take actions, which may include the following:
  - **Peer contact:** The committee may recommend that the CMO or a designated provider contact the practitioner to obtain additional information or discuss the committee's action.
  - **Education:** The committee may recommend that the health plan sends information or educational material to the practitioner or that the practitioner seeks additional training.
  - **Committee appearance:** The committee may recommend that the practitioner attend a committee meeting to discuss the issue with committee members.
  - **Credentials action:** The committee may recommend that all Aetna Medicaid health plans contracted with the practitioner reduce, restrict, suspend, or terminate the practitioner's credentials necessary to treat members as a participating provider.
  - **Corrective Action:** The committee may recommend that all Aetna Medicaid health plans contracted with the practitioner limit the practitioner's new member enrollment, issue sanctions, or require other corrective action.

Under our practitioner participation and peer review policy and procedure, we will also look for any activities that cause harm or might put members at-risk. In addition to the formal peer review sessions, we also conduct routine daily monitoring. Our QM/QI Department will perform monthly analyses on cases to identify any risk of suboptimal care.

PRACTITIONER REVIEWS [SOW 10.4.4, 10.4.5]

Upon recredentialing, QM/QI staff will run a report from the QM Issues database for each practitioner to identify any issues or trends within the last three years. They add this information to the provider's recredentialing file.

The Aetna NQOC QM Department generates a quarterly report to identify practitioners with PQoC concerns that appear across all Aetna product lines (Medicaid, Medicare, and Commercial). An off-cycle review is triggered when a provider has:

- More than two practitioner concerns in a rolling 12-months
- More than five concerns by a vendor or facility that are similar in nature or in the same department in a rolling 12-months

When any event triggers an off-cycle review, the QM/QI Department reviews potential concerns and any history of state license sanctions for the practitioners, vendor, or facility during a rolling three-years. QM/QI documents this for review by the Aetna CPC.

Attachment 5 – Section 10.4, Question 4 [SOW 10.4.1 and 10.4.5]

Describe how critical incidents will be identified, tracked and reviewed and how data gathered will be used to reduce the occurrence of critical incidents and improve the quality of care delivered to members.

Aetna Better Health will track critical incidents through the QM Issues database and will review and analyze critical incidents to identify and address quality of care or health and safety issues. We will base identification of such incidents on the guidelines provided by the Iowa Medicaid Enterprise in the IMPA Form 470-4698 Critical Incident Report Users Guide. We will collaborate with the Agency through the IMPA to assess trends and identify measures and actions to help prevent similar incidents and to educate providers about their responsibilities to reduce the risk of harm to members. In addition, we will track PQoC concerns and the reports of abuse, neglect, and exploitation of children and incapacitated or vulnerable adults, according to Aetna Medicaid and Iowa-specific policies, as outlined above.

10.5 Provider preventable conditions

Attachment 5 – Section 10.5, Question 1 [SOW 10.5, 10.5.1, 10.5.2]

Describe how you will ensure payment is not made for provider preventable conditions.

Aetna Better Health will use the standard Aetna Medicaid program to prevent payment for provider preventable conditions (PPCs). The program identifies and evaluates PPCs, including health-care acquired conditions and other PPCs to comply with federal and state regulations that prohibit Medicaid programs from reimbursing certain providers for services resulting from a PPC.

Our business application system, QNXT™, will pend processing of claims that have diagnosis codes related to PPCs. We will refer these claims to Medical Management clinical staff for investigation and coordination of peer review evaluation by the Credentialing and Performance Committee. Our concurrent review staff may also identify potential PPCs during UM review. Upon identifying a potential PPC, Medical Management staff will refer it to the QM/QI Department for investigation and coordination of peer review evaluation by the Credentialing and Performance Committee.

We will report trends to the QM/UM Committee and recommend interventions for areas of concern. Table 10-27 summarizes the responsibilities of Aetna Better Health staff with regard to PPC.

Table 10-27: Staff responsibilities to identify PPCs

Staff	Responsibilities
Concurrent Review Clinician	• Identify possible PPCs during the concurrent review process • In the authorization record in the Utilization Management module of the claims business application system, note that the claim should be pended for PPC review • Complete the PQoC Investigation Intake form and submit it to QM • Obtain copies of any available medical records that document the concern; attach to the PQoC Investigation Intake form confirmation e-mail and return to QM

Quality Management Nurse	• Investigate the possible PPC
	• Obtain and review additional information from other sources such as:
	  ◦ Medical records
	  ◦ Additional information from the provider or practitioner; for example, relevant policies and procedures, corrective action plans initiated by the provider or practitioner, or other documentation
	• Refer to our CMO or designated Medical Director for review

CMO or designated Medical Director	• Based on clinical judgment, render a final determination on the existence of a PPC
	• Denote findings in the claims business application system
	  ◦ If findings are negative for a PPC, we will turn off the pend claim indicator in the authorization record in the UM module of the claims business application system
	  ◦ If the findings were positive, authorization for the service is denied

Claims Analyst	• Review claims pended for possible PPC to determine whether the CMO or designated Medical Director has completed the review
	  ◦ If the review is not documented in the UM module of the claims business application system, the Claims Analyst follows up with QM for the status of the investigation
	  ◦ If the review is documented, the Claims Analyst processes of the claim in accordance with claims processing standards for PPC, either paying or denying the claim

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Section 11: Utilization Management

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SECTION 11 – UTILIZATION MANAGEMENT

The table below outlines how the Scope of Work provided in RFP Attachment 1 relates to the responses to the questions provided in RFP Attachment 5. We provide this table to reduce redundancy of responses and information and to simplify the evaluation process for the evaluators.

For requirements in Attachment 1 that do not require a detailed response, the table below indicates our intent to comply with the stated requirement in lieu of repeating the RFP question and including a *will comply* statement within the body of the narrative.

Attachment 1 requirement	Cross reference to Attachment 5	Will comply
11.1 Utilization Management Program	Section 11.1, Question 1	Yes
11.1.1 UM Policies and Procedures	Section 11.1, Questions 2.a through 2.j	Yes
11.1.2 Program Elements	Section 11.1, Questions 2.a through 2.j	Yes
11.1.3 Work Plan	Section 11.1, Question 3, Appendix M	Yes
11.1.4 UM Subcontractors and Staff	Section 11.1, Questions 2.h and 4	Yes
11.1.5 Practice Guidelines	Section 11.1, Question 5	Yes
11.1.6 UM Care Coordination	Section 11.1, Questions 2.a - 2.j and 5 - 8	Yes
11.1.7 UM Committee	Section 11.1, Questions 2f and 9	Yes
11.2 Prior Authorization	Section 11.2, Questions 1, 2, 4, 5, 7, 10	Yes
11.2.1 General	Section 11.2, Questions 1, 2, 4, 5, 7, 10	Yes
11.2.2 IDPH Prior Authorization	Section 11.2, Question 3	Yes
11.2.3 Medical Necessity Determinations	Section 11.2, Question 6	Yes
11.2.4 Psychosocial Necessity of Mental Health Services	Section 11.2, Question 6	Yes
11.2.5 Prior Authorization Requests	Section 11.2, Questions 1, 2, 4, 5, 7, 10	Yes
11.2.5.1 Processing	Section 11.2, Questions 1, 2, 4, 5, 7, 10	Yes
11.2.5.2 Exceptions to Prior Authorization and/or Referrals	Section 11.2, Question 10	Yes
11.2.5.2.1 Pharmacy Prior Authorization	--	Yes
11.2.5.2.2 Second Opinions	Section 11.1, Question 10	Yes
11.2.5.2.3 Special Needs	--	Yes
11.2.5.2.4 Women's Health	--	Yes
11.2.5.2.5 Newborn and Mothers Health Protection	--	Yes
11.2.5.2.6 Emergency and Post-Stabilization Care Services	Section 11, Question 10	Yes
11.2.5.2.7 EPSDT	--	Yes
11.2.5.2.8 Behavioral Health Services	Section 11.2, Question 3	Yes
11.2.5.2.9 Transition of New Members	Section 11.1, Question 1	Yes
11.2.6 Tracking & Reporting	Section 11.1, Question 1	Yes
11.2.6.1 PA Tracking Requirements	Section 11.1, Question 1	Yes

Attachment 1 requirement	Cross reference to Attachment 5	Will comply
11.2.6.2 PA Denials	Section 11.1, Question 1	Yes
11.2.7 Notice of Actions	Section 11.1, Question 1 Section 11.2, Question 8, Appendix N	Yes
11.2.7.1 Notification Letters	Section 11.1, Question 1 Section 11.2, Question 8, Appendix N	Yes
11.2.7.2 Time Requirements for Notices	Section 11.2, Question 1	Yes
11.2.7.2.1 Standard Timeframes	Section 11.2, Question 1	Yes
11.2.7.2.2 Expedited Timeframes	Section 11.2, Question 1	Yes
11.2.7.3 Notice of PA Changes	Section 11.1, Question 1 Section 11.2, Question 1	Yes
11.2.8 Objection on Moral or Religious Grounds	Section 11.2, Question 9	Yes

11.1 Utilization Management Program

Please explain how you propose to execute Section 11 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Three Decades of Caring for Those Most Vulnerable

Aetna Medicaid has 30 years of experience in conducting utilization management through our health plans. Aetna Better Health of Iowa, Inc. (Aetna Better Health) will leverage this expertise to implement our Utilization Management (UM) Program. We will:

- Apply established processes for managing, monitoring, evaluating, and improving the utilization of care and services members receive
- Assist members, practitioners and providers in the appropriate utilization of care and service delivery systems, assess information regarding satisfaction with these processes, and discover opportunities to optimize members' health outcomes and manage costs
- Integrate medical and behavioral health care services. Our UM decision-making criteria will use a biopsychosocial clinical model to evaluate the individual needs of each member.

Our UM Program will be integrated with our Quality Management and Improvement (QM/QI) program to align activities with the common principle of providing high quality, cost-effective, outcomes-oriented health care through balancing medical management, operations and finance components.

We uphold the following principles for delivery of exemplary care:

- **A focus on members and recovery** – Our services are distinguished by our commitment to supporting members and their families in achieving overall medical, psychological, and social well-being
- **Leadership involvement and local empowerment** – Strong leadership, direction, and support of quality improvement and UM activities by Aetna Better Health leadership is key to sustaining a culture of exemplary care
- **Continuous, data-Informed improvement** – Data informs practice, and our UM program is an essential resource to effectively manage health care resources and to verify that members receive appropriate and cost-effective care

Our objectives for UM provide a base for the appropriate use of health care resources

The purpose of the Aetna Better Health UM program is to manage using health care resources such that members receive appropriate and cost-effective care. We have adopted the Agency for Healthcare Research and Quality's functional definition of quality as our overall goal for UM: ***Doing the right thing for the right patient, at the right time, in the right way, to achieve the best possible results.***

We will base our UM program in Iowa on the following objectives:

- Coordinating and monitoring the care and services members receive for timeliness, medical necessity, and appropriate setting
- Monitoring and evaluating care and services for accessibility, continuity of care when appropriate and over- or under-utilization of medical resources
- Establishing processes to assist in the identification of quality-of-care, risk management, and UM issues and to develop follow-up measures to remedy the issues identified
- Promoting collaboration among our departments and systems in collecting and sharing utilization data and information
- Integrating all utilization processes to promote continuity of care
- Identifying waste, duplication, delays, and miscommunication in services provided to members and establishing process improvement practices to reduce or eliminate deficiencies
- Improving the clinical and cost-effectiveness of physician practice patterns by promoting using evidence-based clinical guidelines and care pathways
- Supporting effective review and resolution of reconsiderations, grievances, appeals and complaints

Attachment 5 – Section 11.1, Question 1 [SOW 11.1, 11.2.5.2.9, 11.2.6, 11.2.6.1, 11.2.6.2, 11.2.7, 11.2.7.1, 11.2.7.3]

Describe in detail your utilization management program, including how you will operate and maintain the program.

Aetna Better Health's UM program will integrate systems for managing, monitoring, evaluating, and improving the care and services members receive. In this section, we will describe how we will operate and maintain our UM.

Our UM program's foundation is rooted in Aetna Medicaid's best practices

Key functions of the Aetna Better Health UM program will be to:

1. Establish and maintain integrated systems and processes for collecting utilization data, monitoring member and provider utilization patterns, and disseminating information
2. Establish utilization benchmarks, initiatives, and target outcomes that reflect the Aetna Better Health and Iowa's strategic expectations, directions, and goals and comply with federal, state, and local regulations and requirements

Based on Aetna Medicaid established best practices, our UM processes will have protocols for the review of services requested as a pre-service, concurrent service, retrospective service, and for the denial of services. Our UM policies and procedures will be clearly specified in provider manuals and will

be consistently applied under the established UM guidelines, including those of the NCQA. Compensation to individuals or entities that conduct UM activities is not structured to incentivize the individual or entity to deny, limit, or discontinue medically necessary services to any member.

Our UM approach will identify both over- and under-utilization patterns for inpatient and outpatient services through ongoing monitoring, will evaluate patterns to determine root causes, and will implement improvements in processes to address unfavorable patterns. Our process of monitoring, evaluation, and implementation considers the characteristics and health care needs of the member population and the community that accesses care.

Our roadmap for operating and maintaining the UM program

OPERATING: UM PROGRAM RESOURCES AND TOOLS

CHIEF MEDICAL OFFICER

The Aetna Better Health Chief Medical Officer (CMO) will be accountable for directing the development and implementation of the UM program. The CMO will be a board-certified or board-eligible, Iowa-licensed physician who is familiar with the local standards of medical practice and nationally accepted standards of practice.

With the assistance of the Quality Management Department and medical committees, the CMO will oversee performance improvement activities to determine that goals and objectives are met. The CMO will be responsible for leading strategic medical management activities that contribute to our performance and promote quality of care for our members. These responsibilities will include developing and implementing medical programs and policies; analyzing medical cost and return on investment enhancing relationships with practitioners and facilities and regulatory agencies; and serving as a key business ally in network development, product design, and strategic planning. The CMO will be responsible for directing and overseeing the Aetna Better Health prior authorization (PA) function.

DIRECTOR OF MEDICAL MANAGEMENT

Aetna Better Health's Director of Medical Management, in collaboration with the CMO, will be responsible for overseeing the overall administration of the Medical Management Program, which will include UM. The CMO will delegate the authority and accountability for putting the UM Program and Work Plan into effect to the Director of Medical Management. To support the Director, Aetna Better Health will designate a behavioral health practitioner to inform implementation of UM processes and programs with regard to behavioral health aspects of care as well as a Long Term Services and Support (LTSS) professional to inform implementation of UM processes and programs with regard to LTSS aspects of care.

The Director will implement activities that will improve our performance and promote quality of care for our members. These responsibilities will include development and implementation of medical programs and policies; medical cost and return on investment analysis; enhancing relationships with providers, facilities, and regulatory agencies; and acting as a key business ally in network development, product design, and strategic planning. In managing the program, the Director will review the program's goals and objectives, which will include:

- Monitoring of members' receipt of coordinated and high-quality, medically necessary care
- Collaboration with providers in delivering services that are evidence-based and offered with minimal administrative barriers

UM DEPARTMENT

Under the direction of the CMO and the Director of Medical Management, the UM Department will be responsible for monitoring using designated services before delivery to see that services are:

- Provided at an appropriate level of care and place of service
- Included in the defined benefits and appropriate, timely, and cost-effective
- Accurately documented to facilitate accurate and timely reimbursement

The UM Department will consist of clinical and non-clinical staff members, including Concurrent Review Clinicians, Care Management Associates, Inbound Queue Associate, PA Clinicians, and PA Representatives.

Aetna Better Health will maintain sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines. Individuals who conduct clinical review related to utilization review processes will be appropriate health professionals and must possess an active professional relevant license in the state of Iowa. Aetna Better Health staff who conduct clinical reviews will have access to consultation with designated Aetna Better Health Medical Directors who are licensed doctors of medicine or doctors of osteopathic medicine; licensed health professionals in the same licensure category as the ordering practitioner; or health professionals with the same clinical education as the ordering practitioner in clinical specialties where licensure is not issued. Our UM staff will have expertise in physical, behavioral health, waiver programs, and LTSS as well as experience and training in working with adults and children with disabilities and children with special health care needs. Staff will receive training to combine clinical skills with service techniques to support our UM processes, including PA, concurrent review, and retrospective review of services. Our staff will receive initial and ongoing training regularly, but no less than annually.

UTILIZATION MANAGEMENT DIRECTOR (CLINICIAN)

The Aetna Better Health UM Director will be responsible for providing UM Program oversight and management of clinical processes including the organization and development of high-performing teams. The UM Director will administer the UM Program and assist all UM staff in understanding and implementing the clinical philosophy and the related policies and procedures related to the Medical Management Program including the UM program. The UM Director will be accountable for communicating and overseeing implementation of program objectives, fulfilling our responsibilities to our members, and promoting active collaboration with necessary practitioners.

PRIOR AUTHORIZATION CLINICIAN/CONCURRENT REVIEW CLINICIAN

The PA Clinician/Concurrent Review Clinician (PA Nurse/CR Clinician) will use clinical skills to support the coordination, documentation, and communication of medical services or benefit administration determinations. The PA Clinician/CR Clinician will be able to collect information necessary for rendering medical necessity and benefit determinations; he or she will be an able communicator who understands the guidelines, policies, procedures, and standards by which determinations are made.

PRIOR AUTHORIZATION REPRESENTATIVE

The PA Representative will support comprehensive coordination of medical services including intake, screening, and referrals to Aetna Medical Services programs. This position will perform intake of calls from members or practitioners regarding services through telephone, fax, and electronic data exchange. The PA Representative will screen requests for appropriate referral to medical services staff. This

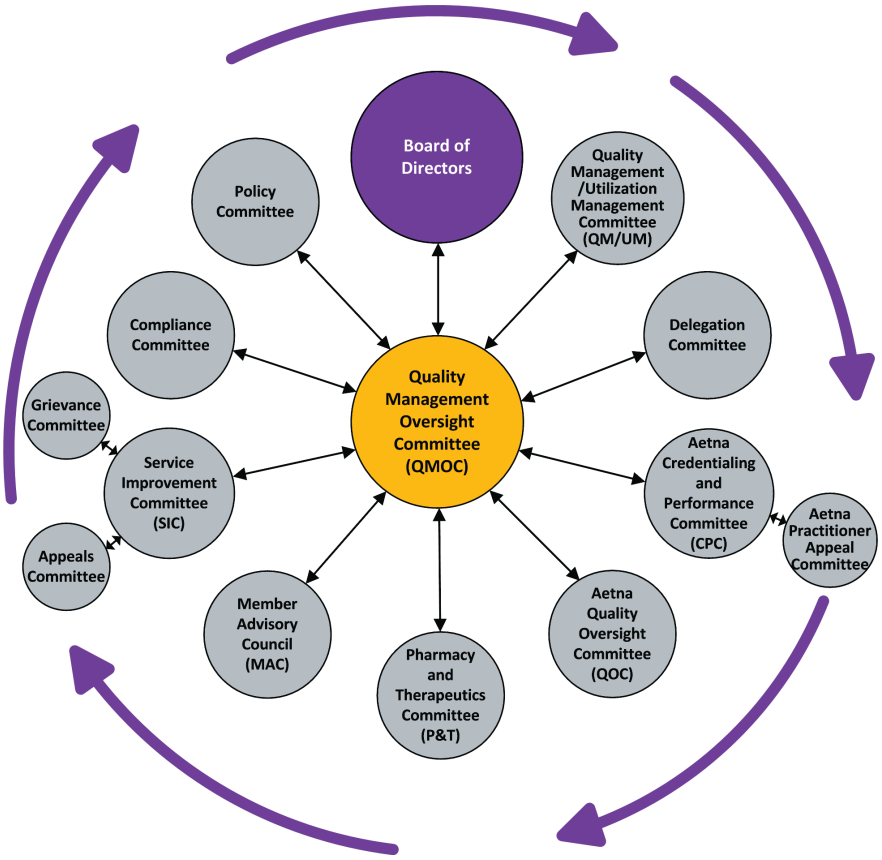
individual will perform non-medical research including eligibility verification, coordination of benefits, and benefits verification.

UM PROGRAM OVERSIGHT AND STRUCTURE

Formal medical committees, subcommittees, and ad hoc work groups will advise and guide the UM program and overall Aetna Better Health QM/QI.

Figure 11-1 illustrates the communications structure of the QM/QI committees that will integrate Aetna Better Health's medical functions, operations departments, the network, and members into utilization activities. Short descriptions of these committees are provided in Section 11.1 in the response to Question 2i.

Figure 11-1: Communications structure for Aetna Better Health QM/QI Committees



Evidenced-based clinical criteria is the groundwork of a successful UM program

Aetna Better Health will seek to reduce and eliminate health inequities and to improve health outcomes of our members. Therefore, we will consider the appropriate and responsive design, dissemination, and deployment of clinical criteria as a priority. We will use nationally recognized, evidence-based review criteria to improve the consistency of decisions made by our clinical UM staff. Clinical criteria will represent best practices, reflect national standards, and support medical necessity determinations in our UM processes. Additional detail regarding clinical criteria is provided in Attachment 5 - Section 11.2.

CLINICAL PRACTICE GUIDELINES

We will make clinical practice guidelines (CPGs) available to practitioners and encourage use to improve appropriate utilization of medications and treatments demonstrated to be effective in treating specific conditions. CPGs will represent best practices that our plans use today and will be based on national standards, reasonable medical evidence, and expert consensus. Before use, the CMO, applicable medical committees, network physicians, and, if necessary, external consultants will review and approve the guidelines. We will review guidelines annually or as often as new information is available. Table 11-1 below provides a list of sources for CPGs that Aetna Better Health will use.

Table 11-1: Clinical practice guideline sources

Guideline	Source
Asthma	National Heart, Lung, and Blood Institute (NHLBI) Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma Full Report 2007
Asthma and pregnancy	Management of Asthma and Pregnancy. HCUSA has adapted the guidelines from the American Congress of Obstetricians and Gynecologists (ACOG) to provide treatment guidance to Primary Care Providers (PCPs); these are not intended to replace or preclude clinical judgment
Attention Deficit/Hyperactivity Disorder (ADHD)	American Academy of Pediatrics (AAP): Diagnosis, Evaluation, and Treatment of ADHD in Children and Adolescents, October 2011
Bright Futures	AAP: Bright Futures
Chronic Obstructive Pulmonary Disease (COPD)	The Global Initiative of Chronic Obstructive Lung Disease – 2014
Coronary artery disease	American Heart Association/American College of Cardiology Foundation (AHA/ACCF) Prevention and Risk Reduction; Therapy for Patients with Coronary and Other Atherosclerotic Vascular disease: 2011 Update
Diabetes	American Diabetes Association Standards of Medical Care in Diabetes, 2014
Gestational diabetes	Management of gestational diabetes and pregnancy. The Guideline was adapted from the ACOG to provide treatment guidance to PCPs and is not intended to replace or preclude clinical judgment
Heart Failure	American College of Cardiology Foundation (ACCF) and the American Heart Association (AHA) Heart Failure Guideline – 2013
Hepatitis C	American Association for the Study of Liver Diseases and Infectious Diseases Society of America: Recommendations for Testing, Managing, and Treating Hepatitis C
HIV/AIDS	Developed by Aetna Medicaid/Medical Management, based on resources from the National Institutes of Health AIDS Info Clinical Guidelines Portal
Hypertension and pregnancy	Management of Chronic Hypertension and Pregnancy: The Guideline was adapted from the ACOG to provide treatment guidance to PCPs and is not intended to replace or preclude clinical judgment
Major depressive disorder	American Psychiatric Association (APA) Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition
Overweight and obesity	Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, National Health Lung and Blood Institute, US Department of Health and Human Services
Preeclampsia and eclampsia	Diagnosis and Management of Preeclampsia: The Guideline was adapted from the American College of Obstetrics and Gynecology (ACOG) to provide treatment guidance to PCPs and OB/GYN practitioners

Guideline	Source
Prenatal and postpartum care	Routine Prenatal and Postpartum Care: The guideline was adapted from ACOG to provide treatment guidance to PCPs and OB/GYN practitioners
Preterm labor	Management of Preterm Labor: The guideline was adapted from ACOG to provide treatment guidance to PCPs
Substance use disorders and pregnancy	Substance use disorders and Pregnancy: The guideline was adapted from ACOG to provide treatment guidance to PCPs
Substance use disorders (adult)	APA practice guideline for the treatment of patients with substance use disorders

DISSEMINATING GUIDELINES

We will use multiple resources and media for dissemination of CPGs to our providers and members. A practitioner may obtain an applicable, current, and valid copy of any CPG from our website or by contacting the Provider Services Representative office. We will also disseminate clinical criteria and CPGs through our PA, Concurrent Review, Quality Management, and Case Management staff when they interact with participating or out-of-network practitioners. We will make clinical criteria and CPGs readily available to our members and potential members through our website, member handbook, and member newsletters or by contacting member services. We will provide all clinical criteria and CPGs used for clinical decision making from public sources to members and practitioners as described in Table 11-2. There is never a cost for members or practitioners who request clinical criteria or CPGs.

Table 11-2*: *Availability of clinical criteria to members and practitioners

Member Information	Provider Information
Aetna Better Health website	Aetna Better Health website
Member Handbook	Provider Manual
Member Newsletters	Provider Newsletters
Care Management team	Provider Services Representatives
Care/Service Plan	Care/Service Plan
Member Call Center (Toll-free call)	Provider Service Center
Notice of Action letter	Service Approvals/Denials Determinations

MONITORING THE EFFECTIVENESS OF GUIDELINES

To assess the effectiveness of the guidelines, we will monitor selected recommended services by providers along with related member outcomes. Our quality committees will evaluate overall performance and assess the need for new programs. We will link the results to individual physician profiles and use these to evaluate over- and under-utilization and determine the need for member and provider education to improve practice patterns. Using guidelines will be essential for the development and monitoring of Integrated Care Management (ICM). We will give feedback to practitioners on individual performance and will monitor and report overall Aetna Better Health plan performance.

DOCUMENTATION

UM staff members will document certain required information about the authorization request:

- Member diagnosis (ICD-9; ICD-10 when required) and other current applicable codes
- Member information
- Primary Care Provider (PCP) or treating practitioner and other involved providers/practitioners
- Reason for the referral
- Clinical information applicable to the request

- Identification of the criteria that supports the decision for medical necessity

The physician reviewer will be responsible for documenting actions taken related to medical review requests confirming that the date(s), final decision, reason for the decision, and criteria used in making the decision are included in the documentation.

DATA SOURCES, ANALYSES, AND REPORTS

We will use a variety of tools to gather, analyze, and report on member and practitioner utilization data. These tools will assist us in tracking usage and identifying trends from multiple perspectives. Table 11-3 summarizes these tools.

Table 11-3*: *Sources for gathering UM data

Source	Description	Purpose	Use
QXNT™	Operating system that will capture member, practitioner, claims, call-tracking, and utilization data and will support all aspects of our QM and UM processes and programs • Claims data • Demographic and enrollment data (including prior coverage data) • Practitioner contract data, including practitioner demographics • PA and special needs data • Electronic Data Interchange and maternity care payments • Medicaid eligibility records	To be **used for problem-solving or the development of corrective action plans**. QM/UM reporting and monitoring uses member, practitioner, claims, encounter, and other data sources	Gathering data
Actuarial Services Database (ASDB)	Comprehensive data warehouse and analytical system that will support reporting and analytical needs by providing multidimensional predictive modeling and statistical outlier analyses	The ASDB houses eligibility, practitioner, PA, pharmacy, and claims data and is a **key source for the data needs of Medical Management, Finance, and Operations**	Gathering data
Case Management System	Principal application used in our ICM Program. The System is a flexible application that supports service coordination, assessments, and development of Plans of Care.	Will support collection and review of the following: • **Assessment** and reassessment deadlines • **Specialty referrals** and special needs tracking • **Service Coordination notes and workloads** and service access • Self-reported **member data obtained through assessment activities** and clinical outcomes • **Community resource** key contacts Other data points, including demographics, diagnosis, PCP, PA, and restrictions	Gathering data
Analytical Applications Web (AAWeb)	A Visual Basic interactive interface that will be used by our analysts as a point-and-click query tool to access reports, review detailed data, and export information from ASDB	AAWeb will generate customized analyses to identify favorable and unfavorable cost and utilization trends, measure performance against benchmarks, and compare summary information	Analyzing data

Source	Description	Purpose	Use
AutoAuth Module	A web-based tool that will streamline the PA processes and improve medical management	Will be used to assess and set priorities for clinical review and intervention	Analyzing data
Utilization Management System	Will provide access to evidence-based best practices and criteria for • Documenting UM decisions • Supporting development of comprehensive, consistent, and coordinated clinical decisions • Identifying gaps in care and improve quality operational efficiency	Will help our Case Managers track variances, quality measures, and overall efficiency	Analyzing data
Practitioner Profiles	Profiles will identify PCP and Patient-Centered Medical Home (PCMH) utilization and quality-of-care issues, as directed by the QM/UM Committee	• Will be used to identify PCP and high-volume specialist utilization patterns that vary significantly from peer network practitioner groups • Will provide information to network PCP and high-volume specialists about their practice patterns • Will provide information to be used as a component of QM oversight • Will provide information to be used as a component of Pay for Quality	Reporting data
Quality Spectrum Insight™ (QSI)	A tool that will generate reports for HEDIS and other performance measures	QSI will use accreditation and business goals for reporting on Agency-defined performance measures	Reporting data
Inpatient Census Tool	Will provide up-to-date information about members who are currently receiving inpatient care to our Concurrent Review clinicians	Will support effective **management and coordination of care activities** for discharge planning	Reporting data
Ad hoc reports from PBM	CVS Health (our Pharmacy Benefits Manager [PBM]) will provide access to a web-based reporting tool to pull ad hoc reports from the claims adjudication system; these reports will track the following metrics: • Overall costs (PMPM – per member per month) • Utilization (scripts/1,000) • Unit costs (average ingredient cost) • Generic rate • Generic substitution rate • Formulary compliance • Percentage of prescriptions filled through mail order • Average population risk (based on Medicaid Rx, a Medicaid pharmacy risk-adjustment tool)	• Analyses will highlight specific drug classes with significant changes in overall cost, unit cost, utilization, or generic rate • Specialized analyses will track members who have prescriptions with multiple prescribers or who are using multiple prescribers and/or multiple pharmacies for controlled substances (for example, benzodiazepines, amphetamines, opioids, narcotics), to identify opportunities for intervention and management	Analyzing data

ANALYSIS AND COMPARISON OF DATA TO TARGETED BENCHMARKS

Our strategies for data analyses include:

- Using quantitative performance indicators
- Assessment of evidence-based standards or benchmarks
- Data sorts by geographic area, practitioner type, or member age cohorts
- Statistical methodologies
- Trending of data over specific periods of time

We will compare our utilization performance measure results to targeted benchmarks such as HEDIS Medicaid 75th percentile to identify areas for improvement. We will use other information management systems and data mining tools to support our analyses, including:

- Aetna Medicaid Quality Consolidated Outreach and Risk Evaluation (CORE) predictive modeling tool (described in detail in Section 10.1, Question 2)
- An interactive graphical user interface that allows access to detailed data in our data warehouse

UM REPORTS THAT EXAMINE UTILIZATION PATTERNS AND TRENDS

Committed to Health Care Transformation

We will use a suite of UM reports that will provide UM leadership with a comprehensive framework to examine utilization patterns and trends. Our UM Medical Director will review data from these reports by convening a weekly interdepartmental UM work group that include staff from Finance, Operations, Medical Management, Care Management, and other areas as necessary. The UM work group will develop comprehensive analyses of utilization data to identify over- and under-utilization of services and unexpected trends.

The UM work group will ascertain root causes and develop recommended interventions to correct variances that may negatively affect member health outcomes and quality of care. The work group will then submit recommendations to the QM/UM Committee for consideration and approval. Follow-up discussions between the UM work group and the QM/UM Committee will focus on tailoring intervention strategies to improve quality and cost-effectiveness across the continuum of care.

Our suite of UM reports for the Agency will include the following:

- Category of Expense reports
- Practitioner profiles
- Pharmacy utilization reports
- ED utilization and cost reports
- Claims reviews
- Consistency of application of medical review criteria including annual IRR assessment
- Consistency in documentation, as assessed by department file audits
- Additional quality and UM indicators

Service authorization processes

Our service authorization processes will review service requests with minimal administrative barriers for providers. We will provide an environment for consistent, collaborative, culturally competent, and optimal utilization of care that is responsive to our providers and members. When applying clinical criteria for PA, Concurrent Review, and Retrospective Review, we will consider the member and the member's support system, culture, diagnosis, disease stage, and past medical history, including

prescribed medicines and services that we, or a previous health plan, have authorized in the past. Our UM Plan and written policies and procedures will include processes, clinical practice guidelines, review criteria, turnaround timeframes, and health plan staff involved in the process. The Plan will also include information about the roles of health plan staff involved, documentation requirements, and other requirements relevant to making medically necessity determinations related to level of care, place of service, scope of service, and duration of service.

Service authorization requests will be completed in a timely and efficient manner in compliance with established turnaround timeframes. At any point in the review process, a member or a practitioner acting on the member's behalf may request an expedited review if a delay in the decision could seriously jeopardize our member's life or health.

PRIOR AUTHORIZATION

Through our PA process, we will review certain services and procedures before the member receives the service to confirm that the services are:

- Requested for eligible members
- Provided at an appropriate level of care and place of service
- Included in the defined benefits, and are appropriate, timely, and cost-effective
- Coordinated as necessary with Medical Management functions (for example, Quality Management or Care Management) and information communicated to applicable operations areas (for example, Finance, Member Services, Provider Services) or per contractual requirement with external contractors
- Accurately documented to facilitate accurate and timely reimbursement and reporting

Aetna Better Health will use nationally recognized, evidence-based medical necessity criteria to support the consistency of decisions made by our clinical UM staff. Before being recommended for use, medically necessary criteria and clinical practice guidelines are reviewed and approved by the CMO, QMOC, and the QM/UM Committee. A detailed description of our PA process is provided below in Section 11.2. PA will not be required for services provided to Iowa Department of Public Health (IDPH) populations.

CONCURRENT REVIEW

The concurrent review process will examine the medical necessity of inpatient admissions and appropriate use of inpatient medical resources for continuing services that hospitalized members receive. Concurrent review activities will also identify occurrences of over- or under-utilization, physician practice patterns, and ways to improve the member's inpatient care outcomes and cost-effectiveness of services. A full description is provided in Section 11.1, Question 2e.

RETROSPECTIVE REVIEW

Under certain circumstances (for example, if Aetna Better Health is notified of a hospitalization after the member's discharge), reimbursement for services provided may be determined retrospectively. We will base our retrospective reviews solely on the medical information available to the attending physician or ordering provider at the time the health care services were provided. Retrospective determinations will be reviewed against the same criteria as concurrent determinations for the same service.

SERVICE AUTHORIZATION DECISIONS

Aetna Better Health will make written or electronic notification available to the practitioner and the member will receive written notification (a Notice of Action) for any decision made to deny, reduce,

suspend, or terminate a service authorization request. Our UM Plan and policies will describe the information contained in a Notice of Action including a description of the members' rights and the process by which they may file an appeal or request a state Fair Hearing.

Our Medical Directors who participate in the UM process and conduct clinical review will be available to discuss review determinations with attending physicians or other ordering providers. Practitioners may request a peer-to-peer consultation to discuss denied authorizations with the Medical Director reviewer by calling the plan.

DISCHARGE PLANNING

Discharge planning is an important UM tool for maintaining continuity of care and preventing re-admissions. Concurrent review clinicians will work collaboratively with hospital discharge planning staff, members or their caregivers, and practitioners to help coordinate the hospital's discharge planning efforts. A team approach will result in better continuity of care in the safest and most cost-effective setting by attending to member social, economic, cultural and language needs.

DATA MONITORING TO EVALUATE INAPPROPRIATE UTILIZATION

As part of Aetna Better Health's comprehensive process for detection, monitoring, and evaluation of over-, under-, and inappropriate utilization of services, we will monitor aggregate data to identify overall trends or data outliers that may indicate inappropriate utilization. Through reports and tools, we will monitor these data monthly, quarterly, and annually and report utilization and performance trends to the QM/UM Committee and the QMOC.

Performance improvement indicators

Aetna Better Health will monitor UM and performance improvement indicators to identify usage patterns, including:

- The timeliness of utilization decisions and notification to practitioners and members
- Accuracy with which utilization information is documented

Results of utilization and performance indicators will be evaluated to identify trends and are included as components of practitioner profiles. The results will be reported by UM staff members to the QMOC subcommittees for recommendation and action, including the Aetna Credentialing and Performance Committee, as needed.

Practitioner profiling

Practitioner profiling and performance reporting will help us monitor provider utilization practices alongside member health outcomes to identify opportunities for improvement. The objectives of the practitioner profiles are to:

- Identify practitioner utilization patterns that vary from peer network practitioner groups
- Identify trends that can be addressed through practitioner outreach
- Provide information to network practitioners about their practice patterns
- Provide information to be used as a component of quality management oversight
- Provide information to be used as a component of practitioner incentive compensation

The CMO will be responsible for accessing the profile interface quarterly to review identified practitioner's utilization patterns, trends, and costs and for distributing the results to applicable network providers. As needed, the CMO may request that the practitioner develop a corrective action plan.

Claims review

Aetna Better Health will evaluate potential over- and under-utilization of medical inpatient services by monitoring the following measures at least monthly or more frequently as needed, based on UM trends:

- Bed days per 1,000 members
- Outlier day reviews
- Readmissions
- Consistency of application of medical review criteria including annual IRR assessment
- Consistency in documentation, as assessed by department file audits
- Additional quality and UM indicators

In addition, claims may be reviewed for correct coding and billing. During review, claims may be identified for potential quality, utilization, and risk issues. These claims will be forwarded to the Quality Management Department for further investigation and resolution. In addition, potential occurrences of fraud or abuse may surface. These cases will be forwarded to the appropriate department for review.

Peer-to-peer consultation

Aetna Better Health Medical Directors who participate in the utilization review process and conduct clinical review will be available to discuss review determinations with attending physicians or other ordering practitioners. We will inform practitioners in the denial letter that they may request a peer-to-peer consultation to discuss denied authorizations with the Medical Director or reviewer by calling us. We will provide, within one business day of a request by the attending physician or ordering practitioner, the opportunity to discuss the denial decision with the Medical Director making the initial determination or with a different Medical Director if the original Medical Director cannot be available within one business day. If a peer-to-peer conversation or review of additional information does not result in a certification, the denial letter informs the practitioner and member of the right to initiate an appeal and the procedure to do so.

Notice of action requirements

We will provide the practitioner with electronic or written notification and the member with written notification (Notice of Action) of any action, not just service authorization actions, within the timeframes for each type of action as required by the Agency and described in state and federal rules, regulations, and policies.

A notice of action will be in writing, provided in alternative formats, translated upon request, and composed at a 6th grade reading level or below using language that is easily understood. We will not reverse a certification determination unless we receive new information that is relevant to the certification and that was not available at the time of our original certification. Sample notices of action are provided in Appendix N.

Continuity of care

We will maintain continuity of care and service whenever a member's care setting or provider changes. Integrated systems and interdepartmental processes will include QXNT™, our integrated business application system that can be accessed by all departments involved in coordinating services for a member. This system will allow departments to share member and provider information to coordinate procedures such as discharge planning, transitioning a member from an institutional setting back into the community, authorization of post-hospital services, and follow up on complex cases or Emergency Department (ED) care.

Aetna Better Health will maintain policies and procedures for monitoring the services of members during transitions of individuals or groups between health plans or during transitions from one practitioner or ancillary provider to another. During such transitions, we will identify and monitor members with high-risk conditions or special needs to arrange for them to receive the previous level of care or service. The Member Services Department is available to assist members in selecting or changing their PCP (and medical home) assignment.

Our Care Management staff will assist members who meet certain criteria to assist in coordinating needed services during a change in the member's level of care. We have explained our Integrated Care Model (ICM) and LTSS services in detail in Sections 4 and 9.

QUALITY, UTILIZATION, AND RISK MANAGEMENT (MEDICAL RECORD REVIEW)

Our QM/QI Department will collaborate with UM to screen and review medical documents to identify potential adverse events as well as quality, utilization, safety, or risk issues in the care or services delivered to Aetna Better Health members. The QM/QI Department will develop indicators for identifying potential over- and under-utilization, including target and performance indicators. The QM/UM Committee will review and approve these indicators before we apply them.

We will require any staff member who perceives a potential quality, risk management, or safety issue to refer the issue to the QM Department. A referral may originate in any Aetna Better Health department, such as Care Management, Utilization Management, Compliance, Grievance and Appeal, or Member Services. The referring department will document the issue on a Potential Quality of Care (PQoC) investigation form and forward it to the Quality Management Department for evaluation. Quality Management nurses may review and assign a different functional area within the organization to review and address the needs as indicated (for example, Grievance and Appeals). Please see our response for Section 11.1 under Question 2.j for additional details.

UM performance

UTILIZATION AND PERFORMANCE IMPROVEMENT INDICATORS

Aetna Better Health will monitor using clinical resources and services using utilization and performance improvement indicators. Indicators may be developed internally or established to reflect Agency regulatory or business requirements and may include HEDIS or other comparable indicators. Utilization indicators will be based on utilization data and information, such as trending reports and data sets showing over- or under-utilization of resources. Quarterly summary of results of utilization/performance improvement monitoring will be evaluated to identify utilization and performance trends. These trends will be reported to the QM/UM Committee and the QMOC.

INTER-RATER RELIABILITY ASSESSMENT

Inter-Rater Reliability (IRR) assessments will measure the objectivity and consistency with which Aetna Better Health staff applies medical necessity criteria. The objectives of the IRR process are to:

- Evaluate annually the degree of consistency and objectivity of medical necessity decisions made by staff who use the criteria
- Evaluate staff's understanding and application of medical necessity criteria used
- Establish a performance improvement plan and appropriate monitoring for staff who score below Aetna Better Health's established IRR target

We use IRRs to evaluate the following staff members:

- Chief Medical Officer
- Medical Directors
- PA clinical staff
- Medical Claims Review clinical staff
- Care Management clinical staff
- Behavioral Health clinical staff
- LTSS clinical staff
- Concurrent Review staff
- Appeal clinical staff

Our Medical Management Department managers will be responsible for developing corrective education plans for staff members who score less than the 85% standard for IRR and for monitoring education or remediation plans until the required target is met. Our IRR Administrator will prepare a summary report of our annual IRR activity for our CEO, CMO, and the QM/UM Committee.

PRACTITIONER PROFILING

Aetna Better Health will use the practitioner profiling process to monitor practitioner utilization practices and member health outcomes to identify opportunities for improvement. The Medical Management Department will be responsible for operations to oversee the profile process, including validation of data reasonableness and activities to monitor use of the profiles (site visits, mailings, tracking outcomes over time). The Aetna Medicaid Informatics and Actuarial Systems Departments will be responsible for operations to maintain and regularly refresh the central database.

The CMO or designated Medical Director will be responsible for accessing the profile interface quarterly to review identified practitioner's utilization patterns, trends, and costs during the previous year. We will distribute the profiles to applicable network practitioners, primarily through secure electronic access. If a profile reflects practices that do not further our health care mission (such as low performance of HEDIS measures), the CMO may request that the practitioner develop a corrective action plan.

PHARMACY MANAGEMENT/DRUG UTILIZATION REVIEW

Aetna Better Health will provide information to members about appropriate prescription drug usage. We will monitor and manage practitioners' prescribing patterns through activities such as educating practitioners regarding practice patterns and intervening with practitioners whose practice patterns appear to be operating outside industry or peer norms. We will design our utilization management of medications to detect, monitor, or manage prescribing patterns to determine that our members are not being over- or under-medicated or treated with inappropriate medications. Aetna Better Health is aware that for many members with mental health conditions, medications are a critical component of successful treatment and recovery. Our UM pharmacy policies will promote improved patient care and safety and health outcomes and avoid cost-driven techniques that pose serious risks to the care of persons with mental illness. Please refer to Section 11.1, in the response to Question 2a for additional details on pharmacy management and drug utilization review.

MEMBER, PRACTITIONER, AND PROVIDER SATISFACTION

We will assess member and provider satisfaction with health care services to identify areas that are working well and to identify opportunities for improvement. Member surveys will be conducted by an Aetna Better Health-approved contractor using nationally standardized CAHPS® ambulatory survey items. Additional focused surveys of specific populations or users of identified services may be conducted at the discretion of the Chief Executive Officer and the QMOC.

Member surveys will include questions related to availability and accessibility of health care, practitioners, utilization, quality of care and service, quality of member services, requests to change practitioners or sites, and cultural competency. Practitioner and provider surveys will address satisfaction with Aetna Better Health's UM procedures (PA, concurrent review) claims processing, and our response to inquiries.

When survey results or other sources such as such as member complaints, grievances and appeals, or performance improvement projects identify areas for potential improvement, we will use a formal process for evaluation. We will prioritize and address concerns, implement interventions, and reassess the issue to determine change and satisfaction. The formal process will include feedback to the members, practitioners, and providers if appropriate as well as reporting to the Board of Directors through QMOC subcommittee minutes.

The QM Department will coordinate satisfaction surveys in collaboration with Member Services, Provider Services, and Administration support staff. When possible, we will review results against previous years' results and national benchmarks to identify changes or additional improvements. We will report the results of the comparison and applicable follow-up actions developed to address unfavorable results to the QM/UM Committee and QMOC.

DELEGATION

As detailed in Response to Attachment 5, Section 11.1, Question 4, we will evaluate the ability of potential delegates and monitors and delegated organizations to confirm that the care or service that we provide to members conforms to standards and requirements stated in our delegation agreement and that decisions made on our behalf are consistent throughout the network.

Attachment 5 – Section 11.1, Question 2 [SOW 11.1.1, 11.1.2, 11.1.6]

Describe your policies, procedures and systems to:

Attachment 5 – Section 11.1, Question 2.a [SOW 11.1.1, 11.1.2, 11.1.6]

Describe your policies, procedures and systems to: Assist utilization management staff to identify instances of over- and under-utilization of emergency room services and other health care services

Our policies, procedures, and systems to identify instances of over- and under-utilization of ED services is described in detail in response to Attachment 5- Section 11.1, Question 2.b. Below we address UM of other health care services, including pharmacy.

ADDRESSING VARIATIONS IN UTILIZATION

During monthly UM staff meetings, we will review UM management reports. After data review, the CMO and the Director of Medical Management may act on the information in several ways, including:

- Performing additional in-depth analyses to improve understanding of trends and variances
- Closely monitoring the data to determine if the trend continues or is simply a one-time anomaly
- Taking immediate action to remedy the situation, especially when patient safety is at-risk
- Referring the issue for further analysis and review

To assess trends and identify member and/or practitioner utilization patterns, we will report utilization data internally to the QM/UM Committee and all appropriate departments including Member Services, Provider Services, Credentialing, Care Management, Quality Management, and Finance. We may also

generate specialty ad hoc reports to correct variances or to develop corrective action plans for individual network practitioners.

UTILIZATION MANAGEMENT INTERVENTION

Our UM Clinicians will conduct clinical analyses of concurrent review and PA data to identify over- or under-utilization and physician practice patterns. We will use these data to monitor outcomes and cost-effectiveness of services by:

- Assessing the medical necessity of admissions
- Monitoring services to see that care is appropriate, timely, and in the right setting
- Screening for potential quality, utilization, or risk issues
- Identifying and referring members who may benefit from Integrated Case Management or a community health program
- Identifying clinical issues and referring them to the CMO or designee for discussion with practitioners

MEDICAL MANAGEMENT INSIGHT

To further support and enhance analysis of utilization trends and patterns, the Medical Management Department will gather additional utilization-related data. Examples include:

- **Annual member and provider satisfaction surveys** – Provides us with feedback on how we are perceived by our key stakeholders, including member questions related to the availability, accessibility, and utilization of services and providers' satisfaction with our UM procedures, claims processing, and response to inquiries.
- **Ambulatory medical record reviews conducted by the QM Department** – Provides us with information about recommended preventive services for adults, children, and pregnant members to address under-utilization of preventive health screenings and services.
- **Aetna Medicaid's unique and proprietary CORE predictive modeling** – Identifies members at high-risk for an inpatient admission or ED visit and stratifies them according to their risk. These analyses will support effective monitoring and analysis of care coordination, including detecting inappropriate patterns of care that may occur in members with complex health care needs.

PHARMACY UTILIZATION MANAGEMENT

Aetna Better Health will implement extensive Pharmacy Utilization Management and Drug Utilization Review (DUR) program. The purpose of this program will be to analyze member and practitioner drug utilization patterns and to develop applicable interventions or educational activities to support effective integration of appropriate medication use and care management. The program will also monitor the quality and appropriateness of care to our members. Our Pharmacy UM program includes:

- Member drug utilization
- Pharmacy dispensing patterns
- Practitioner prescribing patterns
- Drug PA criteria
- Pharmacy Benefit Manager (PBM) oversight activities in maintaining a prospective DUR process for identifying select safety issues at the time of dispensing

Using pharmacy claims data, Aetna Better Health's CMO and Pharmacy Director will monitor daily, weekly, monthly, and quarterly management reports, including:

- Dollars and prescriptions (per member, per month)
- Dollars (per prescription)
- Generic drug, single-source brand drug, and multi-source brand drug usage (percentages of total usage)
- Top 10 therapeutic category drug usage (by dollars and number of prescriptions)
- Top 20 drugs used (by dollars and number of prescriptions)

Based on these reports and trending analysis, we will implement interventions to further improve quality as well as control costs. These interventions may include:

- Provider education (targeted reminders, discussions, intensified review of selected practitioners)
- A requirement for step therapy related to specific medications
- Referring members to ICM
- Referrals to Aetna Better Health Special Investigation Unit
- Member lock-in evaluation

By evaluating the efficacy of our targeted interventions, we can determine if changes will be needed to achieve desired outcomes. We will work with our PBM and ICM team to offer clinical solutions to improve member health and quality of care as well as evaluating opportunities that will reduce total costs. Through a combination of technology and extensive clinical resources, we will direct our PBM to intervene with members and physicians to help improve safety, reduce inappropriate drug utilization, and promote adherence to evidence-based care.

A full description of Aetna Better Health's pharmacy services and associated processes for Medication Therapy Management, retrospective drug utilization review, and the pharmacy lock-in program are provided in response to Attachment 5 - Section 3.2.6.

Attachment 5 – Section 11.1, Question 2.b [SOW 11.1.1, 11.1.2, 11.1.6]

Describe your policies, procedures and systems to: Analyze emergency department utilization and diversion efforts

EMERGENCY DEPARTMENT DIVERSION BEGINS WITH OUR COMPREHENSIVE UNDERSTANDING OF THE ISSUE

Our ED diversion program begins with a comprehensive understanding of the specific issues that drive ED utilization in the Medicaid population. First, through our years of experience, we recognize the complex social, psychological, and economic factors that contribute to morbidity and result in ED visits and hospitalizations. In some cases we know that those ED visits are the result of lack of access to primary care. However, we also recognize that simply facilitating primary care services is not enough; our integrated care model addresses the social determinates of utilization. For those deemed to be super users, we have care managers who work with the member in the community to provide optimal self-management and who arrange for appropriate housing, deliver clinical and non-clinical home services, and facilitate access to behavioral, primary, and specialty care services. In the cases of super users, these members often have high utilization for all services and we work with the member, their caregivers, and community services to reduce the need for excessive visits for inpatient and outpatient services.

Our diversion strategies will include:

1. **Enhancing Primary Care Services through a broad network of PCPs** with open access for Medicaid Members. We will create a network of PCPs geographically situated to cover the entire Iowa population. We work directly with the provider group to help them understand the specific

care issues for our Medicaid members and offer them direct support and tools to provide the most comprehensive care. **We focus on ensuring access to PCMH and Integrated Health Homes.**

2. **Focusing on the high-cost super-users** – Our CORE analysis along with direct provider referral allow us to clearly identify those members early on and address the holistic medical, behavioral, social, and economic issues.
3. **Focusing on members with behavioral issues** – We know from experience that a subset of high ED utilizers have behavioral health/substance use disorders issues and our ICM model is designed to quickly address the BH issues and create long standing care management aimed specifically at the BH drives of ED utilization and facilitate care in Health Homes.

PROACTIVE IDENTIFICATION OF MEMBERS AT-RISK

Aetna Better Health will identify high-risk members using our CORE predictive modeling system, which will provide member-specific scores indicating the overall health risks of each member and the likelihood that the member will visit the ED or experience an inpatient admission in the next 12 months.

Our CORE model is based on:

- Predictive modeling risk score in which the top 1% of members ranked by this score are considered high-risk.
- ED risk score in which a logistic regression model assesses the likelihood of a member using the ED in the next 12 months. Members with a probability of 80% are considered high-risk for an ED visit. Performance of this model has a high predictive value showing that 72.1% of the time, the predicted ED utilization occurs in the next 12 months.
- Inpatient admission risk score in which a logistic regression model addresses the likelihood of a member having an inpatient admission within the next 12 months. Members who have a probability between 50% and 69% are considered medium risk and 70% or more are considered high-risk for an inpatient admission. The risk model excludes maternity admissions. Our risk score methodology also assesses a member's risk of being re-admitted within the next 30 days.

Using CORE as the foundation for identifying members and assigning them to the most appropriate level of support or care management to meet their unique needs, we can design effective interventions that result in improved member outcomes and realized cost savings. Our focus is to help our members learn self-management skills and to provide for the admission of members who need hospitalization while identifying and managing those who would benefit from alternatives such as outpatient care, step-down unit care, observation level of care, or home care.

ANALYZING EMERGENCY DEPARTMENT UTILIZATION

To monitor ED Utilization, Aetna Better Health Medical Management staff will generate and review the following reports:

- High-utilizing members
- ED visits by member and by PCP
- ED visits by diagnosis

Aetna Better Health staff will also monitor providers to identify potential over-utilization patterns by:

- Identifying providers who may be driving inappropriate use of ED services (e.g., providers with after-hours voicemail messages that instruct members to visit the ED with any after-hours problems;

providers who lack urgent, same-day appointment availability; nursing facilities with high ED utilization)
- Identifying members who are high utilizers of ED services for non-emergent conditions and informing their PCPs about over-utilization patterns
- Contacting members who are high ED utilizers and educating them through our care management program about self-management of chronic illnesses and better options for accessing needed care

INTERVENTIONS TO REDUCE INAPPROPRIATE ED UTILIZATION

We will closely monitor trends in ED utilization and implement appropriate interventions to address identified issues. We plan to employ a variety of strategies to monitor and address ED utilization.

CARE MANAGEMENT AND COORDINATION OF SERVICES

Aetna Medicaid has a long history of being in markets new to Managed Medicaid and we understand the ED utilization trends that often accompany newly insured individuals. We work with members to help them understand their new benefits, introduce them to providers, and help the providers understand the important needs for each member. We create specific care plans and service plans that help direct the member to the appropriate services which in some urgent cases is the ED.

Aetna Better Health's Integrated Care Management (ICM) program will identify high-risk members who may have accessed ED services inappropriately to connect them with the right service at the right time. Our ICM staff begin working with the member upon admission into the ED and directly coordinate with the ED physician to create appropriate discharge care plans designed to address the root cause of the ED visit and prevent future avoidable ED visits.

Intensive or supportive Case Managers are responsible for making sure their assigned members see their PCP regularly (once each quarter for those with chronic illnesses) by assisting with scheduling and arranging for transportation, as needed. Before the PCP visit, the Case Manager assists the member in completing a Symptom Checklist to identify any needs or issues that should be addressed by the PCP. The Case Manager also provides the member with a copy of his or her current medications to increase the PCP's awareness of the member's pharmacy use and the other physicians that are prescribing medications.

Case Managers will screen members for unmet behavioral health needs (a frequent driver of ED over-utilization) and assist members in gaining access to needed services. Case Managers will provide educational materials, including information on the locations of Urgent Care settings closest to their home as an alternative to ED utilization. This information will be provided to members and their caregivers during care planning visits and when members transition from higher levels of care to the community. Case Managers will regularly educate members and their caregivers on appropriate usage of emergency services and when and how to contact their PCP.

Our 24-hour Nurse Line is also available to our members as a resource to help triage urgent and non-urgent symptoms and connect directly with the PCP to facilitate appropriate access to care.

EDUCATING PROVIDERS

Aetna Better Health will work collaboratively with providers to address issues that may affect ED utilization, such as prescribing patterns (for example, prescribing asthma controller and rescue medications according to current practice guidelines). Our Medical Management staff may also conduct educational sessions for either an individual practitioner or provider group that we have identified as contributing to excessive ED utilization.

Aetna Better Health believes that we can best serve our members through a collaborative team approach. When a member has an emergency episode of care, our team will coordinate and collaborate with hospital staff to best support appropriate follow-up care. We will do the same if our members are

- **Kentucky ranks sixth in the nation for Emergency Department (ED) visit rates with 519 visits per 1,000 persons. In 2012, the HEDIS ED utilization rate for our Kentucky health plan was 64.71 per 1,000 member months as compared to a national average of 53.17 per 1,000. More than 50% of the Kentucky health plan's ED visits were by members under 18 years of age for non-urgent care such as otitis media and pharyngitis. In response to these findings, the Kentucky health plan implemented a performance improvement project to reduce non-urgent and avoidable ED utilization.**
- **Between the baseline year of 2012 and re-measurement year of 2013, the Kentucky health plan's targeted intervention resulted in an 8.44% decrease in ED visits/1,000 member months, which surpassed our goal to achieve a 2% decrease.**

admitted to an acute care, rehabilitation, or nursing facility. Effective communication with the PCP, Patient-Centered Medical Home, Case Manager, Home and Community-based providers and other providers will be essential. As part of our UM process, discharge planning will begin as soon as the member is admitted.

We will also contact providers with strategies for improving access for their patients in the office or clinic setting rather than the ED. Aetna Better Health's network PCPs will be required to maintain after-hours telephonic access to assist members in obtaining urgent or emergent care. [redacted] **CONFIDENTIAL**

Attachment 5 – Section 11.1, Question 2.c [SOW 11.1.1, 11.1.2, 11.1.6]

Describe your policies, procedures and systems to: Identify aberrant provider practice patterns

Our suite of UM reports will provide UM leadership with a comprehensive framework to examine utilization patterns and trends. Our UM Clinicians will conduct clinical analyses of concurrent review and PA data to identify over- or under-utilization and physician practice patterns. We will use these data to monitor outcomes and cost-effectiveness of services by:

- Assessing the medical necessity of admissions
- Monitoring services to see that care is appropriate, timely, and in the right setting
- Screening for potential quality, utilization, or risk issues
- Identifying and referring members who may benefit from Integrated Case Management or a community health program
- Identifying clinical issues and referring them to the Medical Director or designee for discussion with providers
- After data review, the CMO and the Director of Medical Management may act on the information in several ways, including:
  - Taking immediate action to remedy the situation, especially when member safety is at-risk
  - Performing additional in-depth analyses to improve understanding of trends and variances
  - Closely monitoring the data to determine if the trend continues
  - Referring the issue for further analysis and review

To assess trends and identify provider utilization patterns, we will report utilization data internally to the QM/UM Committee and all appropriate departments including: Member Services, Provider Services, Credentialing, Care Management, Quality Management, and Finance. Specialty ad hoc reports may also

be generated to correct variances or to develop corrective action plans for individual network practitioners.

PRACTITIONER PROFILES

Practitioner profiles will identify trends related to cost, quality, and utilization while establishing the accountability of the practitioner in delivering care for members with complex health care needs. Profiles will summarize member compliance with health and wellness screenings (as defined by HEDIS measures) and provide the practitioner with actionable data in report form. These reports will help practitioners identify members who still need care and services, simplifying the process of contacting members and scheduling appointments.

By examining profiles, we will

- Obtain a multidimensional assessment of PCP performance and support PCMHs and similar models of patient-centered, team-based approaches to care
- Monitor Pay for Quality and total cost of care models
- Support other practitioner quality and value-based payment efforts

MONITORING PROVIDER PRESCRIBING PRACTICES AND MEMBER UTILIZATION

Using pharmacy claims data, we will analyze provider prescribing practices and member utilization patterns to identify opportunities for improvement. Our CMO and Pharmacy Director will review monthly management reports on drug utilization patterns by types of drugs, volume, and cost as well as by member, pharmacist, and practitioner.

Based on trend analyses, we will implement interventions to improve quality and control costs. These interventions may include:

- Provider education (targeted reminders, peer-to-peer discussions, review of selected physicians)
- A requirement for step therapy related to specific medications
- Referring members to ICM

These analyses will allow us to evaluate the efficacy of our targeted member and practitioner interventions and to make changes, if necessary, to achieve desired outcomes.

Attachment 5 – Section 11.1, Question 2.d [SOW 11.1.1, 11.1.2, 11.1.6]

Describe your policies, procedures and systems to: Monitor patient data related to length of stay and re-admissions related to hospitalizations and surgeries

Our UM Department will document notifications of members' facility admissions in Aetna Better Health QXNT system when the notification is received. Concurrent review clinicians will be responsible for seeing that the system record is accurately updated as applicable with the results of concurrent reviews and authorization decisions (please see detailed description of the concurrent review process below, in the response to Question 2e). At a minimum, information recorded must include:

- Specific criteria on which the review and decision are based
- Projected stay goals based on the criteria and the member's condition
- Variances in the member's condition
- Inpatient procedures and dates
- Denials or delay days, including:
  - Reason for denial/delay days

  - Medical Director and attending physician who was contacted
  - Facility staff notified; date and time of notification

- Discharge disposition
- Discharge date with number of days approved at each level of care

MONITORING

Aetna Better Health will monitor potential areas of over- or under-utilization of medical inpatient services using the following criteria:

- Bed days per 1,000, on a monthly basis
- One-day admissions
- Outlier day reviews
- Member outcomes (re-admissions, with assessment of related discharge planning)
- Consistency of application of medical review criteria, measured through the IRR assessment tool
- Quality/UM indicators
- Consistency in documentation by department file audits

RETROSPECTIVE MEDICAL NECESSITY REVIEW

Under certain circumstances (such as hospitalization after the member's discharge), reimbursement for a member's health care may be determined retrospectively. When making post-service reviews, we will base reviews solely on the medical information available to the attending physician or ordering provider at the time the health care services were provided. Post-service determinations will be reviewed against the same criteria as concurrent determinations for the same service.

RETROSPECTIVE MEDICAL CLAIMS REVIEW

Retrospective medical claims review provides a retroactive assessment of selected facility services (including outlier claims) and professional charges for inpatient or, if applicable, outpatient treatment to determine whether care was billed correctly. Claims will be reviewed for correct coding and billing. Potential occurrences of fraud or abuse are forwarded to the appropriate department (Compliance or Finance) for review.

Medical claims review decisions will follow correct coding guides and applicable state regulations. We will complete and return reviews to the Claims Department for disposition within seven days of receiving the claim for review. During review, we may identify claims for potential quality, utilization, or risk issues and then forward them to the QM/QI Department for further investigation and resolution.

Attachment 5 – Section 11.1, Question 2.e [SOW 11.1.1, 11.1.2, 11.1.6]

Describe your policies, procedures and systems to: Assure the appropriateness of inpatient care

CONCURRENT REVIEW

Our concurrent review process will examine the medical necessity of inpatient admissions and appropriate use of inpatient medical resources for continuing services that hospitalized members receive. Concurrent review activities will identify occurrences of over- or under-utilization and physician practice patterns; identify ways to improve the member's inpatient care outcomes; and monitor the cost-effectiveness of the services by:

- Determining whether an admission and subsequent stay are medically necessary
- Confirming that the setting, level of care, and services are medically appropriate and cost-effective throughout the member's stay

- Confirming that the member receives appropriate, efficient, and timely services and that discharge planning is begun early in the stay
- Identifying alternative care options (skilled nursing facility, home health, rehabilitation unit, hospice care) and making recommendations to the discharge planner or treating provider
- Identifying and referring members who could benefit from our care management program or a community health program
- Identifying potential clinical issues based on established criteria and presenting them to the CMO or designated Medical Director for discussion with the member's PCP or treating provider
- Identifying other payers (coordination of benefits, third-party liability, Medicare liability)
- Identifying high-cost cases for reinsurance notification
- Screening for potential quality, risk, or utilization issues
- Documenting authorizations, review updates, clinical consultations, and decisions quickly and accurately

Services subject to concurrent review are those provided in acute facilities, behavioral health facilities, rehabilitation facilities, and skilled nursing facilities. Concurrent Review Nurses working under the direction of the CMO or designated Medical Director complete initial reviews of members' admissions within one business day of the admission. Subsequent reviews are conducted on a schedule determined by the member's reason for admission, type of facility, and location.

For onsite reviews, we will require onsite reviewers to carry their Aetna Better Health-issued ID that identifies them as Aetna Better Health staff and includes their picture and full name. We will require UM staff to identify themselves by name, title, and organization name and upon request verbally inform the member, facility staff, the attending physician, and other ordering practitioners/providers of specific UM requirements and procedures. Onsite reviewers will be required to schedule reviews at least one business day in advance unless otherwise agreed upon with the provider. We require the onsite reviewers to follow reasonable hospital or facility procedures, including checking in with designated hospital or facility staff.

Concurrent Review Nurses will be responsible for:

- Identifying cases that may potentially be denied based on medical necessity during concurrent review of inpatient admissions or ongoing services
- Reviewing potential denials with the Medical Director
- If services are to be denied:
  - Providing written notification of denials to members who could be held financially responsible for their care
  - Notifying the facility's business office or other designated department of decisions to deny or terminate reimbursement within one business day of the decision
  - Documenting or informing data entry staff to document the denial decision in the business application system PA module

Aetna Better Health Medical Directors who participate in the utilization review process and conduct clinical reviews will be appropriate health professionals; will be qualified to render a clinical opinion about the medical condition, procedures, and treatment under review; and will hold a current and valid license in the same licensure category as the ordering provider or as a doctor of medicine or doctor of osteopathic medicine.

DECISION/NOTIFICATION STANDARDS

We will make PA decisions and promptly notify providers and applicable members, and we will adhere to the decision and notification time standards delineated in 42 CFR 438.210 for standard authorization decisions and 42 CFR 438.404 for notices of action. Departments that handle pre-service authorizations will meet the timeliness standards appropriate to the services required.

We will notify the practitioner and provide members (when applicable) with written notification of any decision to deny, reduce, suspend, or terminate a service authorization request or to authorize a service in the amount, duration, or scope that is less than requested. This denial process will apply in cases of:

- **Urgent care denials** – We may notify the provider only, assuming the treating or attending provider is acting as the member's representative
- **Concurrent or post-service denials** – We will, at a minimum, notify the practitioner in writing. Members do not need to be notified of concurrent or post-service denials if there is no financial risk to the member. Members must be notified of denials in all other cases.

DISCHARGE PLANNING

Discharge planning is an important UM tool for maintaining continuity of care and preventing readmissions. Concurrent review nurses will be responsible for identifying a member's discharge needs during admission or extended stay reviews and will assist hospital staff to make certain that post-discharge care is available and that the member's discharge plan is implemented.

Aetna Better Health's Concurrent Review Clinicians will assist facilities in meeting discharge planning requirements by PA of transfers to a lower level of care and coordinating referrals to ancillary services or to Care Management but will not assume discharge services that the hospital is required to provide.

Attachment 5 – Section 11.1, Question 2.f [SOW 11.1.1, 11.1.2, 11.1.6, 11.1.7]

Describe your policies, procedures and systems to: Ensure active participation of a utilization review committee

Aetna Better Health's UM and QM/QI functions will be fully integrated; thus, our QM/UM Committee will serve as the UM Committee. Please refer to our response to Attachment 5, Section 10 for additional details regarding our QM/UM Committee. The QM/UM Committee will be tasked with providing advice and making recommendations to the CMO and the Medical Management, UM, and QM/QI Departments on matters concerning the quality of care and service provided to members.

The QM/UM Committee will be assembled prior to our start date, and membership of the QM/UM Committee will include:

- CMO
- Cross-representation of Iowa providers, including PCPs, medical homes, specialists, behavioral health providers
- Behavioral Health Medical Director
- LTSS Director
- Director of Medical Management
- QM/QI Director
- Director of Health Care Equity
- Support staff, as requested

Periodically, QM/UM meetings will include trained Peer and Family Support specialists from Iowa communities to facilitate improvement of the member experience through open communication and decision making focused on an understanding of the member's needs and desired health outcomes.

Attachment 5 – Section 11.1, Question 2.g [SOW 11.1.1, 11.1.2, 11.1.6]

Describe your policies, procedures and systems to: Evaluate efficiency and appropriateness of service delivery

UTILIZATION MANAGEMENT REPORTING AND ANALYTICS

We will monitor utilization and performance improvement indicators to track the effective use of clinical resources and services. We will develop indicators to track utilization fundamentals and will add others as needed to reflect state regulatory or business requirements; these may include HEDIS or other comparable indicators.

We will regularly monitor the following performance improvement indicators to assess compliance with established performance standards, including:

- The timeliness of utilization decisions and notification to practitioners and members
- Accuracy when documenting utilization information
- Timeliness of referrals to maintain continuity of members' care (for post-discharge services) to obtain assistance in coordinating services (to Care Management), or to follow up on potential issues such as quality, utilization, and risk management referrals
- Actual utilization of services

We will monitor PA processes for:

- Volume of requests received by telephone, fax, and website
- Service level
- Timeliness of decisions and notifications
- Process performance rates for the following, using established standards:
  - Telephone abandonment rate under 5%
  - Average telephone answer time within 30 seconds
  - Percentage of PA requests approved
  - Trend analysis of PA requests approved
  - Percentage of PA requests denied
  - Trend analysis of PA requests denied
  - Consistency in using criteria in the decision-making process among PA staff measured by an annual IRR audits
  - Consistency in documentation by department file audits

QUALITY AND CONSISTENCY OF UTILIZATION REVIEW DECISIONS

IRR assessments measure the objectivity and consistency with which our staff will apply medical necessity criteria. We describe this process in further detail in Attachment 5 - Section 11.2, Question 2.

We will employ a comprehensive approach for supporting access to high-quality care in the most appropriate setting by:

- Drawing from our tools for ICM to assess needs and provide proactive case management to assist members in navigating access to appropriate levels of care.
- Developing a comprehensive provider network and nurturing effective relationships with community agencies to coordinate clinical care with other service needs.

- Working with our providers to identify trends related to cost, quality, and utilization and opportunities to improve member access to appropriate and cost-effective care.

Attachment 5 – Section 11.1, Question 2.h [SOW 11.1.1, 11.1.2, 11.1.4, 11.1.6]

Describe your policies, procedures and systems to: Incorporate subcontractor's performance data

Monitoring subcontractors' performance

We will oversee the delegated functions to confirm that plan members receive safe and optimum quality care and service across the provider network. We will develop and maintain monitoring activities to oversee delegated functions, which include the Delegation Subcommittee that submits recommendations to the QM/UM Committee.

Oversight activities will be ongoing and include regular site visits and review of the delegated contractor's program. To maintain consistency in oversight, we will require the delegated provider to refer certain quality components, such as grievances or ongoing quality issues, to our QM/QI Department.

We will evaluate the ability of potential delegates and monitors in delegated organizations to confirm that the care or service the organization provides to members conforms to standards and requirements stated in our delegation agreement and that decisions made on our behalf are consistent throughout the network.

Attachment 5 – Section 11.1, Question 2.i [SOW 11.1.1, 11.1.2, 11.1.6]

Describe your policies, procedures and systems to: Facilitate program management and long-term quality

Formal medical committees, subcommittees, and ad hoc work groups advise and guide the UM program and overall Aetna Better Health QM/QI.

COMMITTEE FRAMEWORK

The QMOC and QM/UM committee will lead our monitoring, evaluation, and implementation of process improvements. The purpose of the QMOC will be to integrate quality management and performance improvement activities throughout the health plan and the provider network. The purpose of the QM/UM committee will be to advise and make recommendations to the QMOC and Aetna Better Health management about member and practitioner issues.

QMOC participants will be responsible for executive oversight of QM/QI and making recommendations to the Board of Directors about QM/QI activities. The committee will be the conduit for communication and decision making across the health plan through its interaction with all other committees.

Aetna Better Health will have supporting committees to integrate our medical functions, operations departments, the network, and members into utilization activities. We will leverage the expertise and best practices of Aetna Medicaid for our Quality Assessment and Improvement committee structure.

QUALITY MANAGEMENT/UTILIZATION MANAGEMENT COMMITTEE

The CMO will chair the committee, which will report to the QMOC. The group will advise and make recommendations to the CMO on matters concerning the quality of care and service provided to members including the oversight and maintenance of the QM/QI and UM programs.

DELEGATION SUBCOMMITTEE

The purpose of the Delegation Subcommittee will be to advise and make recommendations to the QM/UM Committee about delegated relationships. We will not delegate QM/QI activities. We may delegate limited medical management activities.

AETNA CREDENTIALING AND PERFORMANCE COMMITTEE

The QMOC will delegate credentialing decision-making authority to the Credentialing and Performance Committee (CPC) for credentialing and recredentialing individual practitioners who deliver services to members. This group will conduct professional review activities involving the practitioners whose professional competence or conduct adversely affects, or could adversely affect, the health or welfare of members. The CPC will support the Aetna Practitioner Appeal Committee.

AETNA QUALITY OVERSIGHT COMMITTEE (QOC)

The QMOC will delegate authority to the QOC to conduct credentialing and recredentialing and the review of PQoC issues and complaints of facilities, organizational providers, and contractors.

SERVICE IMPROVEMENT COMMITTEE

The purpose of the group will be to advise and make recommendations to the QMOC and Aetna Better Health management about member and practitioner issues. The Grievance and Appeals Committee will support the Service Improvement Committee.

MEMBER ADVISORY COMMITTEE

The purpose of the Member Advisory Committee (MAC) will be to promote collaborative efforts to enhance the service delivery system in local communities while maintaining member focus and allow participation in providing input on policy and programs. Our MAC Plan will outline the schedule of meetings and goals for the council, including members' perspectives about improving quality of care.

COMPLIANCE COMMITTEE

The Compliance Committee will review, monitor, and assess the effectiveness of our compliance plan. The Manager of Compliance and the Compliance Committee will have the responsibility and authority for carrying out the provisions of the compliance program. These individuals will be accountable to the Aetna Better Health Board of Directors and senior management.

POLICY COMMITTEE

The Policy Committee will provide a forum for the consistent development, implementation, approval, and communication of all our policies and procedures. Policy Committee participants will maintain written guidelines for developing, reviewing, and approving all policies and procedures and will review all policies and procedures at least annually to verify that the health plan's written policies reflect current practices. The health plan CEO will date and sign reviewed policies.

Attachment 5 – Section 11.1, Question 2.j [SOW 11.1.1, 11.1.2, 11.1.6]

Describe your policies, procedures and systems to: Identify critical quality of care issues

As discussed above, the Medical Management Department will work in collaboration with UM to screen and review medical documents to identify potential adverse events as well as quality, utilization, safety, or risk issues in the care or services delivered to our members. The Medical Management Department will develop indicators for identifying potential over- and under-utilization, including target and performance indicators. The QM/UM Committee must review and approve these indicators before we

can apply them. We will provide the initial draft of these documents to the Agency within 30 days of contract execution.

We will require any staff member who perceives a potential quality, risk management, or safety issue to refer the issue to the Quality Management Department. A referral may originate in any Aetna Better Health department, such as Care Management, UM, Compliance, Grievance and Appeal, or Member Services. That department will document the issue on a PQoC investigation form and forward it to the Quality Management Department for evaluation. Quality Management nurses may review and assign a different functional area within the organization to review and address the needs as indicated (for example, grievance and appeals). The Quality Management staff document and track PQoC issues in the PQoC business applications system.

The CMO or designated Medical Director will oversee the peer review investigation of issues referred, following the quality review process that includes:

- Concurrent or retrospective evaluation of medical records to determine the quality of the care and services provided
- Referral of potential issues to the QM/UM Committee or Aetna Credentialing and Performance Committee for review and recommendation
- Notification to the Board of Directors indicating the decision and course of action rendered by the Aetna Credentialing and Performance Committee
- Analysis of identified issues for tracking and trending
- Reporting of findings to designated committees quarterly
- Notification the appropriate regulatory board or agency of provider contract termination, suspension, or limitations due to quality-of-care issues
- Development and implementation of corrective action plans as necessary
- Provision of Fair Hearing right to providers

Indicators used to identify potential quality, risk management, and safety issues are specific to Aetna Better Health and will be approved by the QM/UM Committee and the QMOC.

Attachment 5 – Section 11.1, Question 3 [SOW 11.1.3]

Provide a sample UM Work Plan.

Our UM plan is fully integrated with our QM/QI annual work plan; a draft plan is provided in Appendix M.

ANNUAL UM WORK PLAN

Our UM Plan will include an annual work plan that specifies projected UM activities, designated staff and department responsibilities, and the resources required to complete the work plan within anticipated timeframes. The work plan documents the plan for and status of annual UM activities; this plan is fully integrated with our annual QM/QI plan.

The Medical Management Department will prepare the annual UM work plan and submit it for review and approval to the Quality Management/Utilization Management (QM/UM) Committee and the QMOC. Each quarter, the Medical Management Department will review the UM work plan with the Medical Director to monitor progress and update or revise activities as necessary. We will then report the outcomes of these quarterly reviews to the QM/UM Committee, QMOC, and Iowa Department of Human Services (the Agency).

We will review our UM Plan annually, revise it as necessary, and submit it for approval to the Quality Management Oversight Committee (QMOC, described in Section 10) and the Agency. The UM Plan will follow NCQA requirements for UM program structure and will document the following:

- Program goals and objectives
- Major components and activities
- Scope and content of the program
- Roles and responsibilities of individuals, departments, and committees involved in the program
- Role, structure, and functions of our departments and medical committees in carrying out quality improvement activities

Attachment 5 – Section 11.1, Question 4 [SOW 11.1.4]

Describe if any UM functions will be delegated. If any functions will be delegated, describe proposed ongoing monitoring strategies of the delegated entity.

Delegation of UM functions

Aetna Better Health will delegate UM functions for radiology and imaging to MedSolutions, which recently merged with CareCore National, LLC. Pharmacy benefit management functions will be delegated to CVS Health.

Aetna Better Health will evaluate the ability of potential delegates and monitor delegated organizations to confirm that the provided care or service conforms to standards and requirements stated in our delegation agreement and that decisions made on our behalf are consistent throughout the network. Generally, we do not delegate Quality Management, Member Services, or Grievance and Appeals activities. Aetna Health Management, LLC, on our behalf, may perform oversight of delegates in common with us. Aetna Better Health and Aetna Health Management, LLC are affiliates under common ownership of Aetna Inc.

Aetna Better Health will use subcontractors with an established positive presence in Iowa and a successful relationship with us for a variety of services that may inform or affect UM. We contract with both Aetna-affiliated and non-affiliated subcontractors. It is our policy to contract with Aetna affiliates for services in support of the Contract to the fullest extent possible because it allows us to more closely monitor and promote quality and compliance. Our primary considerations as we select non-affiliated subcontractors are service, cost, and compliance. We select and use non-affiliated subcontractors only when we are certain that the subcontractor will perform the services as efficiently or better we can due to the subcontractors' greater capacity, specific experience, or expertise.

Monitoring subcontractors' performance

We will oversee the delegated functions to confirm that plan members receive safe and optimum quality care and service across the provider network. We will develop and maintain monitoring activities to oversee delegated functions, which include the Delegation Subcommittee that submits recommendations to the QM/UM Committee.

Oversight activities will be ongoing and include regular site visits and review of the delegated contractor's program. To maintain consistency in oversight, we require the delegated provider to refer certain quality components, such as grievances or ongoing quality issues, to our QM/QI Department.

We will evaluate the ability of potential delegates to confirm that the care or service the organization provides to members conforms to standards and requirements stated in our delegation agreement and that decisions made on our behalf are consistent throughout the network.

Attachment 5 – Section 11.1, Question 5 [SOW 11.1.5, 11.1.6]

Describe the process for developing and updating practice guidelines.

Aetna Better Health will adopt evidence-based Clinical Practice Guidelines (CPGs) from nationally recognized sources to promote consistent application of evidence-based treatment methodologies. CPGs will be made available to practitioners to facilitate improvement of health care and reduce unnecessary variations in care. Table 11.1 above, provides a comprehensive list of CPGs.

Determining the relevance of guidelines to our members' needs

We use various data sources to determine relevance of practice guidelines to our members' needs:

- Health care claims
- Health care encounters
- Health care delivery costs
- Frequency of hospital admissions
- Frequency of ED visits

To assess the effectiveness of the guidelines, we will monitor selected recommended services by providers along with related member outcomes. We will monitor performance against two aspects of care for four CPGs (including two that focus on behavioral health) to determine how providers adhere to our approved CPGs. We will review HEDIS Effectiveness of Care outcomes, if applicable, and other data as needed.

In parallel, our QMOC and associated subcommittees will evaluate overall performance and assess the need for new programs. We will link results to individual practitioner profiles and use this information to evaluate over- and under-utilization and to determine the need for member and provider education to improve practice patterns or the need for a thorough review of the associated CPGs.

Ongoing collaborative review of guidelines

Our CMO, applicable medical committees, network physicians, and external consultants will review and approve national guidelines as changes occur or no less than annually. The review process will examine information contained within guidelines to make certain the guidelines remain consistent with medical advancements in technology and standards of care. Recommendations for updates developed through this process will be submitted to the QM/UM Committee for final approval.

Development and adoption of new practice guidelines

Like ongoing review of current guidelines, our CMO, applicable medical committees, network physicians, and, if necessary, external consultants will collaborate to develop or adopt new CPGs. The review process will examine information contained within guidelines to make certain the guidelines remain consistent with medical advancements in technology and standards of care. Recommendations for adoption of new CPGs will be submitted to the QM/UM Committee for final approval.

Disseminating guidelines

We will use multiple resources and media for dissemination of CPGs to our providers and members and we will maintain a complete inventory of all CPGs on our website. We will also use the following formats for disseminating the guidelines:

- Provider Manual
- Provider newsletters
- Blast faxes
- Site visits and individual practitioner training
- Provider group meetings

A practitioner may obtain an applicable, current, and valid copy of any CPG from our website or by contacting our Provider Services Department. We will also disseminate the guidelines through our PA, Concurrent Review, Quality Management, and Case Management staff when they interact with participating or out-of-network providers. We will provide access to CPGs current and potential members through our website, Member Handbook, member newsletters, or through contact with Member Services.

Attachment 5 – Section 11.1, Question 6 [SOW 11.1, 11.1.6]

Describe how your UM program will integrate with other functional units as appropriate and support the Quality Management and Improvement Program.

Aetna Better Health's UM Program will be fully integrated with our Quality Management and Improvement (QM/QI) program to align activities with the common principle of providing high quality, cost-effective, outcomes-oriented health care by balancing medical management, operations and finance components.

Our UM and QM/QI programs will be collaborative, systematic approaches to monitoring, evaluation, and implementation of improvements to deliver exemplary patient care and sustain excellence in organizational operations. An effective UM program will be essential to the efforts of our QM/QI Department in monitoring care delivery systems, identifying potential areas of concern, and directing interventions for improvement. Our quality management and improvement efforts will reach beyond the traditional health plan clinical quality approach, thinking ahead about the technology and services that will accelerate the transformation of health care. UM is fully integrated with QM/QI through the objectives of:

- Coordinating and monitoring the care and services members receive for timeliness, medical necessity, and appropriate setting
- Monitoring and evaluating care and services for accessibility, continuity of care when appropriate, and over- or under-utilization of medical resources
- Establishing processes to assist in the identification of quality of care, risk management, and UM issues and develop follow-up measures (including action plans) to remedy the issues identified
- Promoting collaboration among our departments and systems in collecting and sharing utilization data and information
- Integrating all utilization processes to promote continuity of care
- Identifying waste, duplication, delays, and miscommunication in the medical services provided to members and establish process improvement practices to reduce or eliminate deficiencies
- Improving the clinical and cost-effectiveness of physician practice patterns by promoting using evidence-based clinical guidelines and care paths
- Supporting effective review and resolution of reconsiderations, grievances, appeals and complaints

Attachment 5 – Section 11.1, Question 7 [SOW 11.1.6]

Describe how the UM program will encourage health literacy and informed healthcare decision-making.

Tools to Promote Health Care Equity

Aetna Better Health understands that health literacy significantly affects member decision-making, and that successful health education and promotion is vital to improving member health outcomes. As part of our health education and promotion efforts, we will adopt the 2013 enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.

CLAS Standard 1

Principal Standard: Provide effective, equitable, understandable, respectful, and quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs

We embrace both the spirit and letter of the Principal Standard, and we hold ourselves accountable to it. We will continue to work with both individuals and community groups to connect with members, providers, and communities in Iowa. We will participate in Aetna Medicaid's national Health Care Equity (HCE) program. This program exemplifies our commitment to effective and equitable care and services by respecting and honoring, each member's cultural health beliefs, practices, preferred language, and socio-economic background. A comprehensive description of our HCE program is provided in our response to Attachment 5, Section 6.1.4.

Because our members' needs and socioeconomic backgrounds will be diverse, we will tailor our words, the tone of our messages, and any graphic representations in member materials to meet their needs, preferences, and expectations. The Center for Plain Language has recognized the efforts of our parent organization to improve the simplicity and clarity of communication. They have awarded Aetna, Inc. the top honor for their Plain Language Award for the past five years.

We will distribute easily understood information on the following topics to our members through our website and member newsletters and mailings. These topics are presented in a way that educates our members and helps them to understand how to take control of their health by maximizing the services they receive:

- **What Health Care Really Costs** – On our website, we will have a webpage that explores the cost of preventive care compared to accessing emergency care for preventable conditions. This information helps to underscore the importance of establishing a strong relationship with a primary care provider.
- **Prevention and Wellness** – We will also include a webpage dedicated to Prevention and Wellness resources, including information about the following:
  - Weight Management and Nutrition
  - Heart Health
  - Diabetes Self-Management Program
  - Heart Failure Management
  - Asthma Management
  - Chronic Obstructive Pulmonary Disease (COPD) Management
  - Kids Health
  - Vaccination Schedule: 0-6 Years
  - Vaccination Schedule: 7-18 Years
  - Tobacco Cessation Resources
- **Collecting and Maintaining Member Demographics** – Key to optimal service planning and delivery is learning about our members' service needs, preferences, and expectations through information on the enrollment roster and through a personal welcome call with the member. We specifically ask the member to share with us individual preferences for written and oral communication, and we offer the member the opportunity to self-identify by race and ethnicity. We verify and update member information periodically and during each encounter. All of this information will support our

efforts to develop, implement, and measure the effectiveness of our program to provide culturally and linguistically appropriate care and services to targeted populations.

- [redacted] - CONFIDENTIAL
- **Member Reminders** – For targeted populations, we will send reminders to encourage compliance with care guidelines. For example, to encourage adherence to the vaccination schedule for adolescents, we will send birthday cards to teen members to remind them to schedule an appointment with their provider to obtain the appropriate vaccinations.

Attachment 5 – Section 11.1, Question 8 [SOW 11.1.6]

Describe strategies to monitor member access to preventive care and strategies to increase member compliance with preventive care standards. Describe how you will identify and address barriers which may inhibit a member's ability to obtain preventive care.

Connecting our members to preventive care is Job 1 for all Aetna staff. In this section we will outline the many ways we continuously:

- Monitor access to preventive care
- Connect members to preventive care
- Remove barriers to preventive care

In this section we detail our approaches to preventive care connection success.

Many of our Aetna Medicaid health plans consistently score above the 90th percentile in both HEDIS and CAHPS measures related to preventive care.

Strategies to monitor member access to preventive care

Building and maintaining a strong provider network, evaluating quality metrics, and measuring member satisfaction are key strategies to successfully monitoring access to preventive care.

BUILDING AND CONTINUOUSLY MONITORING OUR PROVIDER NETWORK

Convenient access to providers you trust is arguably the number one factor in motivating folks to seek preventive care. As discussed in detail in Attachment 5, Section 6, we will build and continuously monitor a comprehensive provider network capable of meeting or exceeding Iowa's access standards: an essential component of improving preventive care.

We will use GeoAccess software to effectively and efficiently determine provider network accessibility, identify and address network gaps, and analyze that we have the right providers in the right areas to support our members. Initial report runs will be weekly through implementation, monthly through 90-day transition period, and then quarterly or as needed to support effective access monitoring.

We will apply a variety of monitoring tools to make certain that members have adequate access to care, including after-hours access to care, as follows:

1. A cross-functional team that meets weekly to evaluate member complaints, including those regarding after-hours access
2. Monthly site visits to PCP offices where Provider Services Representatives emphasize after-hours access standards
3. Evaluation of ED data to determine whether a PCP is noncompliant with after-hours access requirements
4. Availability surveys sent to members that include questions regarding after-hours access

5. Annual provider surveys, where we assess ability to accommodate after-hours access according to standards.
6. Provider secret shopper surveys by telephone regarding appointment and after-hours access for primary, maternity, and high-volume specialty care

WORKING CROSS-FUNCTIONALLY TO ANALYZE ACCESS TO CARE DATA

All Aetna departments play a role in maintaining and improving access to care. Health Plan leadership takes a cross-functional, collaborative approach to analyzing a variety of data, reporting tools and feedback mechanisms. Please refer to our responses to Attachment 5, Sections 9 and 10 for more detailed information regarding our Quality Management and Care Coordination approaches.

Departments work together to analyze utilization reporting to review care gaps, prevalent conditions, prior authorization data, single case agreements, provider referral issues (availability of specialists), out-of-network requests, appointment availability, appointment wait times, reported quality of care concerns, Emergency Department utilization, and provider credentialing reporting. Further strategies and tactics will be developed to assist providers who underperform in quality or operational metrics.

As discussed further in Attachment 5, Section 9, once a barrier to care is identified, whether at the individual member level or at an operations or provider network level, corrective action is taken swiftly.

MONITORING MEMBER SATISFACTION

All Aetna staff is empowered and encouraged to not only report barriers to care, but resolve them.

Our Hotline, Member, Provider, and Clinical Care teams use our online systems and tools to keep each other informed on the pulse of our membership and statistics related to preventive care connection.

Again, we take a cross-functional approach, working collaboratively to analyzing Member Advisory Committee findings, Member Grievance and Complaint reporting, and member survey results (including after-hours access) relative to the adequacy of our network and meeting member expectations. We will also meet regularly with our transportation vendor and other key subcontractors to review member satisfaction relating to their performance.

Meeting members where they are: strategies to increase member compliance with preventive care standards

In our experience, successful preventive care strategies are all about member preference, choice, and convenience. We offer a variety of member outreach and education strategies that connect members to the right provider environment that meets their needs and the needs of their families. [redacted] **- CONFIDENTIAL**

AN EFFECTIVE MEMBER WELCOME PROCESS

Through our Welcome Packets, Welcome Calls, website, and our mobile app, we will offer a variety of convenient ways for members to learn about how to access preventive care.

All of these options feature clear messaging about the benefits of completing an initial screening and scheduling a preventive care visits with the provider of their choice.

Members have the opportunity to complete an initial health risk screening via:

- **Mail** – Each Welcome Packet contains a health risk screen with postage-paid envelope

- **Online** – our screening tool will be NCQA-compliant with new Member Connections standard
- **Telephone** - for members contacted by telephone, a more comprehensive Health Risk Questionnaire can also be completed depending upon member needs and risk stratification score stratification.
- **In Person** – for members electing to meet with an Aetna Care Management team member

Completion of the risk screen gives us a more detailed picture of the member's physical, behavioral, social, functional, and psychological status and needs. This helps us tailor the best approach to preventive care including identifying:

- A primary care provider or Integrated Health Home if one has not been selected
- Pharmacy support including helping members transfer prescriptions
- [redacted] - CONFIDENTIAL
- [redacted] - CONFIDENTIAL
- Community-based programs that support the member's goals
- Care Management options

Results of our member outreach using motivational interviewing techniques are impressive. In one of our earliest pilots, our staff incorporated motivational interviewing into one of our disease management programs. In two years patient engagement increased from 53.1% to 76%, while the dropout rate decreased 55%. We anticipate similar success in Iowa, as every member-facing staff will be trained in MI techniques.

ALIGNING MEMBER NEEDS AND PERSONAL GOALS

For members who speak to our staff during a Welcome Call, nurse hotline call, or during a face-to-face visit, they will benefit from our extensive training in Motivational Interviewing (MI).

The benefit to the member is that, through non-judgmental, open-ended questions and reflective listening, our staff can quickly and accurately understand what is most important to the member and tailor services accordingly. Obtaining this information allows us to meet a member's unique needs by:

- Connecting them to the right PCP, Integrated Health Home, or specialist to get initial preventive care
- Educating them on our benefits and services as well as additional community supports
- Identifying barriers to care (location of providers or pharmacy, lack of transportation)
- Addressing any cultural challenges and concerns that might delay care connection

AETNA DATA TOOLS TO IDENTIFY GAPS IN PREVENTIVE CARE

As discussed in more detail in our response to Attachment 5, Section 9, we use a variety of screening and assessment tools to identify gaps in care and track down critical data such as patient history, coordinating information from other providers, behavioral health and prescription data. These efforts are designed to help the provider gain a clearer understanding of our member's history and their goals, making appointments more meaningful.

Data tools and reporting to increase compliance with preventive care standards include:

- Using our Care Gap Report daily for early outreach and identification of members who have not had a provider visits, immunizations, etc.
- Use of our Quality CORE tool to help identify which members will need additional outreach reach by the health plan.

- Use of the Health Risk Assessment to further stratify a member's needs. It also functions as a source of referral into the appropriate Care Management program.
- Outreach members telephonically, electronically, and by mail as applicable to remind them of needed services.
- Text messaging to a member's cell phones or through the SafeLink Program.
- Gaps in Care alerts in our Web-based care management application system – the alerts provide CM with a specific list of care gaps for this assigned members. The gaps are addressed when CM outreaches to the member.

To make certain that strategies to increase compliance are effective, ongoing monitoring will be conducted continuously to improve completion rates for applicable services. Strategies will be adjusted accordingly to increasing compliance. The health plan will be using the Plan Do Study Act approach and other quality tools to make certain that members are receiving needed services.

SUPPORTING LONG-TERM BEHAVIORAL CHANGE WITH EDUCATION AND INCENTIVES

We know that once a member is connected to a primary care provider or medical home, additional support may make all the difference in that member's ability to reach their preventive care and other health goals. We are here to help.

In a provider's office, important preventive advice such as a better diet, regular exercise, and medication adherence may be understood and initially agreed to, but good intentions can quickly dissipate in the everyday stress of life.

We are here to help.

To support our members, we send reminders for preventive care visits via written communication, outreach calls, and through our mobile app. Members also have access to Member Services and Nurse Line staff trained in MI techniques that can help make appointments, answer questions, and offer further supports such as directing a member to Aetna incentive programs. -

MEMBER AND PROVIDER INCENTIVES FOR SELECT MEASURES TO HELP MEET OR EXCEED PREVENTIVE CARE COMPLIANCE.

Outside of the office visit, we offer a variety of supports and services to encourage long-term behavior change: **- CONFIDENTIAL**

[redacted]

Identifying and addressing barriers to preventive care

Understanding barriers is a requirement for removing them. Our experience has taught us that MI techniques are helpful in understanding what is important to a member, as is member education and working closely with the Iowa provider community to increase the availability and access to preventive health services.

Barriers to access to care can be identified by over-utilization of Emergency Department visits; member complaints and grievances related to transportation; telephonic outreach to the member from CM or other departments; Member Services; through our annual member satisfaction survey (CAHPS); and by providers and provider geographic assess reports.

Barriers are addressed as applicable. If there is a housing or food need, the CM will work with the member to locate community resources. If it is a provider access issue, Provider Services works to make certain that members have access to an adequate primary care network and transportation assistance in addition to educating providers on clinical practice and preventive care guidelines.

Although recommended preventive services such as colon cancer screening, mammograms, vaccinations, diabetes screening, and blood pressure screenings are provided at no cost, it does not mean a barrier has been removed. For many of our members, making the time for the appointment and arranging transportation and childcare are the biggest barriers to getting those services.

Our member education and outreach efforts are targeted to identify and remove those barriers. For example, a member may not realize they do not have to make an appointment with their primary care provider to get a flu shot. Member Services can identify a local pharmacy to get that flu shot, making it more convenient for the member.

A member may have problems getting their prescriptions filled in a timely manner. We have medication adherence supports in place that range from education, automatic refills, and mail order pharmacy that delivers right to our members' homes.

Although we offer a variety of preventive care strategies, we find that in many instances we need to take an individualized approach. For our members with chronic conditions, we know maintaining good health is often more complex; more barriers exist that may require more engagement. Members receiving care management or chronic condition management may receive assistance from their Case Manager in getting these critical services.

Whatever the challenge, we have the tools, resources, and skilled staff to meet them.

PROOF THAT AETNA PREVENTIVE CARE STRATEGIES WORK

Throughout our proposal, we highlight proof points and data that demonstrate our success in population health management. Tables 11-4 and 11-5 include some recent HEDIS and CAHPS scores that show that our preventive care strategies are working and will work in Iowa.

***Table 11-4: Aetna Medicaid 2013 HEDIS scores above the national 90th percentile*-CONFIDENTIAL**

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Table 11-5: Aetna Medicaid 2013 Adult CAHPs scores above the national 90th percentile-CONFIDENTIAL

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Attachment 5 – Section 11.1, Question 9 [SOW 11.1.7]

Describe your UM Committee, including proposed committee composition and tasks.

Aetna Better Health's UM and QM/QI functions will be fully integrated; our QM/UM Committee will serve as the UM Committee. The QM/UM Committee is tasked with providing advice and making recommendations to the CMO and the Medical Management, UM, and QM/QI Departments on matters concerning the quality of care and service provided to members. Tasks of the Aetna Better Health QM/UM Committee will include:

- Providing oversight for QM and UM functions by:
  - Approving policies and procedures and reviewing the effectiveness of UM processes and making changes to processes as needed
  - Recommending and directing QM and UM activities and policy and operations changes

  - Monitoring consistent application of medical necessity criteria, evidence-based clinical criteria and CPGs
  - Monitoring over- and under-utilization and reviewing outliers
  - Monitoring results of medical records reviews and associated corrective action plans
- Identifying opportunities to improve the equity and integration of services provided to members by:
  - Reviewing and evaluating data sets and other information, such as member demographics, costs, performance indicator results
  - Reviewing and approving studies, standards, clinical guidelines, trends in UM and QM/QI measures, and outcomes
  - Reviewing results of provider medical record reviews and member/provider satisfaction surveys
  - Reviewing and recommending approval, revision, or denial of medical review criteria
  - Evaluating the results of QI/QM activities (such as HEDIS® results, reports, data sets, study results, and general information related to programs, systems, and processes)
  - Conducting peer review and investigating quality of care, service, and member safety issues
  - Reviewing quarterly utilization reports from delegated entities

The QM/UM Committee will meet monthly, keeping confidential minutes. The Aetna Better Health QMOC and the Board of Directors will receive recorded minutes. Minutes will be provided to the Agency upon request.

Membership of the QM/UM Committee will include:

- CMO (chairperson)
- Cross-representation of network providers, including PCPs, medical homes, specialists, behavioral health providers
- Behavioral Health Medical Director
- Director of Long Term Services and Supports
- Director of Medical Management
- QM/QI Director
- Director of Health Care Equity
- Support staff, as requested

Periodically QM/UM meetings will include trained Peer and Family Support staff from Iowa communities to facilitate improvement of the member experience through open communication and decision making focused on a true understanding of the member's needs and desired health outcomes.

Attachment 5 – Section 11.1, Question 10 [SOW 11.2.5.2, 11.2.5.2.2, 11.2.5.2.6]

Describe any benefits which are proposed to require PCP referral and what services would be available on a self-referral process.

PCP Referral

We encourage primary care relationships. However, no services will require a PCP referral, as member access to care is important for all members. A specialist may also serve as a PCP.

Self-Referral

Aetna Better Health members may be entitled to refer themselves to certain medical specialists for specific services as identified in the member's benefits plan or Member Handbook or in State or federal regulations. For example, a member's access to emergency services is not restricted and does not require PA or referral. A member is not restricted in their choice of health care practitioner or provider

for family planning services. If a provider refers a member to a provider of a non-covered service, the provider must inform the member of his or her obligation to pay for such non-covered services.

Our members will have the right to receive a second opinion and are provided information on how to obtain the second opinion. We will maintain a second-opinion process as part of the UM program. Second opinions may be used by the member as an option for the diagnosis and treatment of serious medical conditions, such as cancer, and for elective surgical procedures. Access to a second opinion is not based on a diagnosis. If network providers are used, no PA or referrals are required to obtain a second opinion. Out-of-network providers may be used if the network is limited in the specialty for which the opinion is requested.

11.2 Prior authorization

Attachment 5 – Section 11.2, Question 1 [SOW 11.2, 11.2.1, 11.2.5, 11.2.5.1, 11.2.7.2, 11.2.7.2.1, 11.2.7.2.2, 11.2.7.3]

Describe policies and procedures for processing authorization requests including when consultation with the requesting provider will be utilized.

Prior authorization

Our PA policies and procedures will outline the PA request process. During PA, we will review selected outpatient services and procedures and non-emergency or elective hospitalizations to confirm:

- Eligibility of the member receiving the service
- Appropriateness of the level of care and place of service
- Timeliness and cost-effectiveness of the service and whether the service is part of the defined benefits
- Coordination and communication requirements with Medical Management or other functions (such as Quality Management or Care Management); applicable operations areas (such as Finance, Member Services, and Provider Services); or external contractors
- Accurate documentation to facilitate accurate and timely reimbursement and support reporting

By verifying these elements before the member receives the service, we can verify timely and accurate reimbursements to providers.

To determine whether we will require PA for certain services, we will use data such as utilization data that identifies services likely to be overused or that may be potential signal conditions that might require extensive clinical or care management intervention. We will communicate information about PA requirements to providers in the Provider Manual, on the plan website, in provider newsletter articles, and in provider contracts. We will also directly send the requirements to network providers upon request.

Licensed Nurses will evaluate and document PA requests. The Medical Director may approve other units to prior authorize specific services within their area of responsibility. PA staff will document requests and research the member's electronic files to confirm the member's enrollment and coverage of the service, determine the provider's network affiliation, identify potential coordination of benefits issues, determine whether the service and setting requested are consistent with our criteria for coverage, and coordinate a higher level review of the request if applicable.

Certain services may be authorized by a Licensed Practical Nurse working under a registered professional or Advanced Practice Nurse's supervision if the request is supported by approved review criteria. However, any request that does not clearly meet criteria for coverage as well as any potential denial must be reviewed by the Medical Director or a designated Medical Director. The Medical Director or designated Medical Director may decide to deny authorization based on clinical criteria or benefit coverage. Only a Medical Director may decide to deny an authorization based on medical necessity and appropriateness. If a decision requires specialized judgment, we will have a list of specialist physicians who are available to participate in the utilization review process.

Our Medical Directors who participate in the utilization review process and conduct clinical review for medical necessity will be qualified, as determined by the Medical Director or Clinical Director, to render a clinical opinion about the medical condition, procedures, and treatment under review and hold a current and valid license in the same licensure category as the ordering practitioner or as a doctor of medicine or doctor of osteopathic medicine.

All UM decisions consider the appropriateness of care and service. We do not compensate providers or other individuals conducting utilization review for denials of coverage or service. Financial incentives for decision-makers do not encourage denials of coverage or service.

PRIOR AUTHORIZATION VALIDITY

Unless a member's benefits plan, a provider's contract, or our requirements specify differently, a PA number will be valid for the date of service authorized or for a period not to exceed 60 days after the date of service authorized. The member must be enrolled and eligible on each date of service.

DOCUMENTATION

Staff document certain required information about the authorization request and include diagnosis including the ICD-9 code (ICD-10 when implemented), other current applicable codes, member information, PCP or treating practitioner (including the clinician's signature and credentials), and other involved providers along with their contact information, reason for the referral, clinical information applicable to the request, and identification of the criteria that supports the decision for medical necessity. The physician reviewer handles documenting actions taken for medical review requests and that the documentation identifies the dates, final decision, reason for the decision, and applied criteria.

CONSULTATION WITH PROVIDERS

Aetna Better Health medical directors that participate in utilization management processes and conduct clinical review will be available to discuss review determinations with attending physicians or other ordering providers. Providers are notified that they may request a peer-to-peer consultation to discuss denied authorizations with the medical director reviewer by contacting us.

DECISION/NOTIFICATION STANDARDS

We make PA decisions and promptly notify providers and applicable members. We will adhere to the decision and notification time standards delineated in 42 CFR 438.210 for standard authorization decisions and 42 CFR 438.404 for notices of action. Departments that handle pre-service authorizations will meet the timeliness standards appropriate to the services required.

EXTENSION OF DECISION TIMES FOR NON-URGENT PRE-SERVICE DECISIONS

Non-urgent PA decisions may receive an extension of up to 14 additional calendar days if the member or requesting provider requests the extension or we need the extension to obtain additional information to

make the decision and the extension is in the member's best interest. If we fail to respond to a member's prior authorization request within three business days of receiving all necessary documentation, the authorization is deemed to be granted and notice is given.

We will notify the member and requesting provider in writing of the need for an extension within 14 calendar days of a pre-service request. We will follow up with the requesting provider for an additional 14 days to obtain the additional information. If the provider does not respond, we will refer the request to the Medical Director for review for potential denial. The notice must include the specific information needed to make the decision and the amount of time given to provide the information. The notice must also inform the member of the right to file a grievance if he or she disagrees with the decision to extend. We may deny the request if the needed information is not received within this timeframe. The member may file an appeal.

We will give notice on the date that timeframes expire if we have not yet reached an authorization decision. Untimely service authorizations constitute a denial and are considered adverse actions.

EXTENSION OF TIMEFRAMES FOR URGENT PRE-SERVICE DECISIONS

We may extend urgent PA decisions up to 48 hours (or according to regulatory requirements) if the member or requesting provider requests the extension or if we need the extension to obtain additional information to make the decision and the extension is in the member's best interest.

We will notify the member and requesting provider in writing of the need for the extension within 24 hours of receipt of the request. The notice must include the specific information needed to make the decision and the amount of time given to provide the information and must inform the member of the right to file a grievance if he or she disagrees with the decision to extend. We may deny the request if the needed information is not received within this timeframe. The member may file an appeal. We will give notice on the date that timeframes expire if the authorization decision has not been reached. Untimely service authorizations constitute a denial and are considered adverse actions.

EXTENSION OF TIMEFRAMES FOR URGENT CONCURRENT DECISIONS

The timeframe for making an urgent ongoing care decision may be extended if:

- The request to extend the urgent ongoing care is not made at least 24 hours before the expiration date of the prescribed period of authorization or number of treatments. Any requests that are received late will be handled as urgent pre-service decisions and the decision will be made within 72 hours.
- The request to approve additional days is related to care not previously approved by Aetna Better Health and we document that we made at least one attempt to obtain needed clinical information within the initial 24 hours after the request for coverage of additional days. In this case, the decision must be made within 72 hours.
- The member voluntarily agrees to extend the decision-making timeframe.

If a request to continue ongoing care does not meet the definition of urgent care, the request may be handled as a new request and decided within the timeframe for non-urgent PA requests.

POLICY FOR EMERGENCY SERVICES

If the member is admitted for the treatment of an emergency medical condition, members may receive emergency medical services both in and out of our network without first obtaining PA. We will not withhold payment for such services from providers, regardless of network status. However, we

encourage the provider to notify us, which helps us coordinate care and participate in discharge planning. The PA Department will document the notification.

We will cover emergency and post-stabilization services rendered by qualified participating or out-of-network providers after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

POLICY FOR OUT-OF-NETWORK PROVIDERS

When approving or denying a service from an out-of-network provider, we will assign a PA number, which will refer to and document the approval. We will send written documentation of the denial to the out-of-network providers within the timeframe specified in the table above. Occasionally, a member may receive a referral to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. We will decide this on a case-by-case basis in consultation with our Medical Director.

MONITORING

Aetna Better Health's CMO and the Director of Medical Management will analyze utilization data on a monthly basis to identify areas of concern in the plan's performance and develop recommendations for action planning. At a minimum, the CMO will present this information to the QM/UM Committee. The QM/UM Committee will provide feedback to the CMO and will approve any action plans, including adjustments to the QM/QI program.

We will monitor PA processes for:

- Volume of requests received by telephone, fax, and website, respectively
- Service level
- Timeliness of decisions and notifications
- Process performance rates for the following, using established standards:
  - Telephone abandonment rate (under 5%)
  - Average telephone answer time (within 30 seconds)
- Percentage of PA requests approved or denied
- Trend analysis of PA requests approved or denied
- Consistency in using criteria in the decision-making process among PA staff measured by an annual IRR audits
- Consistency in documentation by department file audits

Attachment 5 – Section 11.2, Question 2 [SOW 11.2, 11.2.1, 11.2.5, 11.2.5.1]

Describe mechanisms to ensure consistent application of review criteria for prior authorization decisions.

Consistent application of UM review criteria

We employ five approaches to establish consistent application of review criteria and to prevent arbitrary or inappropriate denial of services:

1. Application of current clinical criteria
2. Application of clinical knowledge and expertise of reviewers
3. No incentives to reduce utilization
4. Documentation and review
5. IRR audits

When we evaluate an individual member's utilization of services, we will consider the member's support system, culture, diagnosis, disease stage, and past medical history, including prescribed medicines and services we (or a previous health plan) may have authorized in the past.

APPLICATION OF CURRENT CLINICAL CRITERIA

The clinical guidelines we use for UM represent best practices and are based on national standards, reasonable medical evidence, and expert consensus. Before use, the CMO, applicable medical committees, network physicians, and, if necessary, external consultants review and approve the guidelines. We review guidelines at least every two years, or as often as new information is available.

Our protocols for developing, reviewing, adopting, and annually evaluating clinical criteria are based on a formal and systematic review of nationally recognized standards and take into consideration local and regional practice patterns. Aetna Better Health's clinical criteria will follow:

- State or federal guidelines
- Our documented UM policies and procedures
- MCGs—formerly Milliman Care Guidelines
- Level of Care Utilization System (LOCUS)
- Child and Adolescent Service Intensity Instrument (CASII)
- Aetna Clinical Policy Bulletins (CPBs)
- Aetna Medicaid pharmacy guidelines

CLINICAL KNOWLEDGE AND EXPERTISE OF REVIEWERS

We will employ clinical professionals with UM expertise, including those with experience in working with populations with complex physical and basic behavioral health care needs. Our UM team will use their clinical and customer service skills to support the coordination of our UM Program with members, PCPs, and providers.

Qualified and trained providers will apply state and federal regulations when determining medical necessity. We will use our medical necessity definition. Staff members who conduct utilization review will be appropriate health professionals and must possess a relevant and active Iowa professional license. Staff members will have access to consult with designated Aetna Better Health Medical Directors who are licensed doctors of medicine or doctors of osteopathic medicine, licensed health professionals in the same licensure category as the ordering provider, or health professionals with the same clinical education as the ordering provider in clinical specialties where licensure is not issued.

The UM Department will collaborate with other program areas, such as Quality Management, Care Management, Actuarial Services, Member Services, and Provider Services to facilitate the UM program. Our UM staff have expertise in physical, behavioral health, waiver programs, and LTSS, as well as

experience and training in working with adults and children with disabilities and families of children with special health care needs.

Clinical review responsibilities include:

- Identifying service requests that may potentially be denied on the basis of medical necessity
- Forwarding potential denials to the CMO or designated Medical Director for review if services are to be denied
- Providing written notification of denials to members who could be held financially responsible for their care
- Notifying the requesting provider and member of the decision to deny or terminate reimbursement within the applicable timeframe
- Documenting, or informing data entry staff to document, the denial decision in the business application system PA module

Aetna Better Health UM professionals will have expertise in acute care (maternity; preventive; Early Periodic Screening, Diagnosis, and Treatment; and well-woman and well-man services). Our staff will receive training to combine clinical skills with service techniques to support UM processes including PA, concurrent review, and retrospective review of services. The CMO, in collaboration with the UM Coordinator, will be responsible for oversight of each level of UM including day-to-day program operations and activities. The Medical Director and staff members from clinical PA, Concurrent Review, Care Coordination, and Appeals are responsible for each level of UM decision making.

NO INCENTIVES FOR REVIEWERS TO REDUCE OR DENY SERVICES

Compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member per 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.

DOCUMENTATION AND REVIEW

For Service Authorization requests, our UM staff will document required information about the authorization request, including diagnosis code (ICD-9; ICD-10 when required); other current applicable codes; member information; the name and contact information for the PCP or treating provider and other involved providers; clinical information applicable to the request; and identification of the criteria that supports the decision for medical necessity. The UM reviewer documents the actions they took for each medical review request: dates, final decision, reason for the decision, and criteria used.

For inpatient admission reviews, the UM Department records the admission in our business application system. Our Concurrent Review Clinicians update the record as applicable with the results of concurrent reviews and authorization decisions. They record at least the following information:

- Specific criteria on which the review and decision are based
- Projected stay goals based on the criteria and the member's condition
- Variances in the member's condition
- Inpatient procedures and dates
- Denials or delay days, including reason for denial or delay days
- Medical Director and attending physician who was contacted
- Facility staff notified; date and time of notification
- Discharge disposition
- Discharge date with number of days approved at each level of care

We will review utilization and performance improvement indicators to track the effective use of clinical resources and services. We will develop indicators to track utilization fundamentals and will add others as needed to reflect state regulatory or business requirements; these may include HEDIS or other comparable indicators. The indicators are based on utilization data and information, such as trending reports and data sets showing over- or under-utilization of resources or identifying specific diseases or large populations with a specific disease.

We will regularly monitor the following performance improvement indicators to assess compliance with established performance standards, including:

- The timeliness of utilization decisions and notification to providers and members
- Accuracy with which utilization information is documented
- Timeliness of referrals to maintain continuity of members' care (for post-discharge services); to obtain assistance in coordinating services (to Case Management); or to follow up on potential issues (quality/utilization/risk management referrals)
- Utilization of services

INTER-RATER RELIABILITY ASSESSMENTS

IRR assessments will measure the objectivity and consistency with which Aetna Better Health staff applies medical necessity criteria. The IRR process will:

- Conduct annual evaluations of the consistency and objectivity of medical necessity decisions made by our staff
- Evaluate staff member understanding and application of medical necessity criteria
- Establish a performance improvement plan and appropriate monitoring for staff who score below our IRR target

Medical Management Department supervisors must develop corrective education plans for their staff members who score less than the 85% standard and monitor the progress of these plans until the member meets the required target. The IRR administrator prepares an annual summary report of the IRR results and delivers the report to the Chief Executive Officer, CMO, and the QM/UM Committee.

Attachment 5 – Section 11.2, Question 3 [SOW 11.2.2, 11.2.5.2.8]

Describe processes for retrospective utilization monitoring for IDPH population services.

Retrospective medical claims reviews will be conducted by a physical health or behavioral health care professional that has appropriate clinical expertise in treating the member's condition or disease. Prior authorization will not be required for any level of service for the IDPH population.

Reviews will assess selected facility services (including outlier claims) and professional charges for inpatient or, if applicable, outpatient treatment to determine whether the provider billed us correctly for the care. Aetna Better Health will review these claims for correct coding and billing. If the review discovers a potential case of fraud or abuse, we will forward the materials to our Compliance or Finance Departments.

We will base medical claims review decisions on correct coding guides and applicable Iowa and federal regulations. The UM Department will complete the review and returns the results to the Claims Department for disposition within seven days of receiving the claim for review. During review, UM might discover potential quality, utilization, or risk issues and forward the claim to the Quality Management Department for further investigation and resolution.

Attachment 5 – Section 11.2, Question 4 [SOW 11.2, 11.2.1, 11.2.5, 11.2.5.1]

Describe required staff qualifications for UM staff.

Our UM Department will include clinical and non-clinical staff members, including Concurrent Review Clinicians, PA Inbound Queue Associates, PA Nurses, and PA Representatives. The UM Manager will be an Iowa-licensed Registered Nurse who oversees the UM programs and processes under the direction of the CMO. We will employ clinical professionals with UM expertise, including those with experience in working with populations with complex physical and basic behavioral health care needs.

Qualified and trained providers will make determinations of medical necessity according to State and federal regulations. We will use the Agency's medical necessity definition. Staff members who conduct utilization review will be appropriate health professionals and must possess a relevant and active Iowa professional license. Staff members will have access to consult with designated Aetna Better Health Medical Directors who are licensed doctors of medicine or doctors of osteopathic medicine, licensed health professionals in the same licensure category as the ordering provider, or health professionals with the same clinical education as the ordering provider in clinical specialties where licensure is not issued.

Table 11-6 identifies required staff qualifications for UM staff.

Table 11-6: UM staff qualifications

Title	Type	Qualification criteria
Medical Director	Clinical	Iowa board-certified, licensed physician
UM Director	Clinical	Iowa-licensed physician, physician's assistant, or licensed registered nurse
PA Nurse	Clinical	Iowa-licensed registered nurse
PA Representative	Non-clinical	High school graduate with experience in medical terminology or provider office experience
Concurrent Review Clinician	Clinical	Iowa-licensed RN or LPN
Retrospective Review Clinician	Clinical	Iowa-licensed RN or LPN

Attachment 5 – Section 11.2, Question 5 [SOW 11.2, 11.2.1, 11.2.5, 11.2.5.1]

Describe proposed utilization management clinical standards, including the use of any nationally recognized evidence based practices.

Utilization Management clinical standards

We will use the following guidelines for medical necessity reviews:

- For physical health, MCG is the primary decision support for most diagnoses and conditions. MCG updates the guidelines annually, based on frequent research by MCG physicians, nurses, and epidemiologists. MCG also provides access to chronic care guidelines and patient educational materials to coach members as they move to self-care management.
- As the primary decision support for most behavioral health diagnoses and conditions, the Level of Care Utilization System (LOCUS) are the clinical guidelines for making decisions regarding medical

necessity for behavioral health and substance use disorders. The American Association of Community Psychiatrists (AACP) developed LOCUS for adults. We will also use the Child and Adolescent Service Intensity Instrument (CASII), which was developed by the Work Group on Systems of Care of the American Academy of Child and Adolescent Psychiatry. This instrument incorporates developmental, family, and community systems of care perspectives. Developmental status determines the cut-off between LOCUS and CASII.

- We will use CPBs developed by Aetna Medicaid. Aetna develops these CPBs using peer-reviewed medical literature; technology assessments and structured evidence reviews; evidence-based consensus statements; expert opinions of health care practitioners; and evidence-based guidelines from nationally recognized professional health care organizations and public health agencies.

Our protocols for developing, reviewing, adopting, and annually evaluating clinical criteria are based on a formal and systematic review of nationally recognized standards and take into consideration local and regional practice patterns. Aetna Better Health's clinical criteria will consider:

- Written UM policies and procedures developed by Aetna Better Health
- MCG
- CMS regulations
- Agency requirements
- Aetna CPBs
- Clinical Pharmacology

Our process also will also include using several evidence-based medicine sources to access and validate our clinical criteria. We may survey or consult multiple sources during this process, including:

- U.S. Food and Drug Administration
- ClinicalTrials.gov
- National Guideline Clearinghouse
- Centers for Medicare & Medicaid Services
- Centers for Disease Control and Prevention
- National Asthma Education Prevention Program Guidelines
- National Heart Lung and Blood Institute
- American Heart Association
- National Institute of Diabetes and Digestive and Kidney Diseases
- American Diabetes Association
- International Association for Hospice & Palliative Care (IAHPC)
- Infectious Diseases Society of America (IDSA)

Attachment 5 – Section 11.2, Question 6 [SOW 11.2.3, 11.2.4]

Describe how you will identify those services that will be reviewed for medical necessity determination. Provide a list of services for which prior authorization would be required.

We categorize services requiring medical necessity review based on State and federal regulations and guidelines. Only qualified, trained providers will make determinations of medical necessity. Staff members who conduct utilization review will be appropriate health professionals and must possess a relevant and active Iowa professional license.

To support medical necessity decision making, Aetna Better Health uses evidence-based criteria, which we apply to health care service requests based on the needs of individual members and the

characteristics of the local delivery system. Our QM/UM Committee and QMOC review criteria annually and update them as necessary. Our criteria are reviewed above in Section 11.2, Question 5.

We use several strategies so members with behavioral health disorders receive optimal treatment. We want to minimize reliance upon ED visits, inpatient hospitalization, long-term residential treatment, and other long-term institutional placements. We facilitate a collaborative determination of the most effective treatment. Our service array includes a continuum of care with home and community-based wraparound services and supports. In alignment with the Mental Health Parity Act of 2008, we eliminate barriers to appropriate care by optimizing access to and availability of these alternatives. We make it easier for people to get effective treatment earlier in the course of their illness, which results in better outcomes.

A complete list of services for which PA will be required is provided in Appendix N.

Attachment 5 – Section 11.2, Question 7 [SOW 11.2, 11.2.1, 11.2.5, 11.2.5.1]

Describe your prior authorization request tracking system.

Aetna Better Health will use well-developed software tools to facilitate the process of PA and track data related to requests and their resolution, as detailed in Table 11-7.

Table 11-7: Components of Aetna Better Health's PA Tracking System

Component	Data Input	Report Outputs
Auto-Authorization Module	• Service authorization requests • Member demographic and enrollment data • Provider data	• Provides guideline content directly to the provider for potential auto-authorization • Service authorization determinations
UM System	• Service authorization requests from providers • Member demographic and enrollment data • Provider data •	• Service authorization review and determinations for inpatient and outpatient requests • Provides guideline content directly to the staff for review of medical necessity criteria and monitoring of effective UM processes • Reporting based on service authorization processes
ProPAT	• Service authorization requirements • Benefit information • Service partner detail • Benefits plan guidance	• Based on entry of Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes, user receives report on which code(s) are valid, expired, a covered benefit, the code's PA requirement, and any noted PA exception information • Entry of a CPT group (selected from a dropdown list) will return the information for all CPT/HCPCS codes in the specified group. The display can be filtered to sort only those codes that have a PA requirement.
ProREPORT	• Provider quality and utilization reports • Provider membership information	• Provider reports (view only)

Component	Data Input	Report Outputs
Notice of Action System	• Trigger authorization updates that meet the selection criteria for NOA letter generation • Customize member-specific reasons for NOA	• Search, display, and export historical NOA records • Maintain copies of letters that have been translated into alternative languages • NOA denial letter audit tracking and reporting • Member NOA (includes PA status) letters • Batch printing • Outbound fax (to provider) capabilities
ProFAX	• Incoming faxes are securely routed through a secure system into ProFAX	• Incoming faxes are securely routed through a secure system into ProFAX

Attachment 5 – Section 11.2, Question 8 [SOW 11.2.7, 11.2.7.1]

8. Provide sample notices of action as described in Section 11.2.7.

We will provide the practitioner with electronic or written notification and the member with written notification (Notice of Action) of any decision to deny, reduce, suspend, or terminate service authorization request limits or to authorize a service in the amount, duration or scope that is less than requested or denies payment, in whole or part, for a service.

A Notice of Action will be in writing and composed at a 6th grade reading level or below using language that is easily understood. We will not reverse a certification determination unless we receive new information that is relevant to the certification and that was not available at the time of our original certification. Sample notices of action are provided in Appendix N.

Attachment 5 – Section 11.2, Question 9 [SOW 11.2.8]

9. Indicate if your organization elects not to provide, reimburse for or provide coverage of a counseling or referral service because of an objection on moral or religious grounds.

Aetna Better Health anticipates that no counseling or referral services will be excluded because of an objection on moral or religious grounds.

Attachment 5 – Section 11.2, Question 10 [SOW 11.2, 11.2.1, 11.2.5, 11.2.5.1]

Describe your program for ongoing training regarding interpretation and application of the utilization management guidelines.

We will provide a comprehensive training program to prepare new UM staff members and reinforce that with ongoing, required training to provide consistency in interpretation and application of the UM guidelines. Table 11-8 outlines our training program.

Table 11-8: Both initial and ongoing training emphasize consistency and accuracy in interpretation and application of UM guidelines

Frequency	Topics covered
Initial	• A comprehensive overview of organizational culture, including corporate values, ethics, and focus on providing an environment that is member-centric • Training and testing in mandatory compliance and ethics training, including HIPAA, Ethical Code of Conduct; Fraud, Waste and Abuse; Diversity; Reporting Abuse and Neglect • Job-specific training on appropriate application of UM clinical criteria (MCGs and Aetna CPBs) and clinical practice guidelines

Frequency	Topics covered
Ongoing	• Participation in online training application that provides access to MCG learning center and which includes processes to test ability to apply the criteria appropriately • Case reviews by supervisors validate adherence to policies and procedures • At least monthly, each supervisor runs standardized audit reports on activities that profile operational quality including a UM staff member's activities, compliance with timeframes, adherence to policies and procedures, and completeness of work

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Section 12: Program Integrity

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SECTION 12 – PROGRAM INTEGRITY

The table below outlines how the Scope of Work provided in RFP Attachment 1 relates to the responses to the questions provided in RFP Attachment 5. We provide this table to reduce redundancy of responses and information and to simply the evaluation process for the evaluators.

For requirements in Attachment 1 that do not require a detailed response, the table below indicates our intent to comply with the stated requirement in lieu of repeating the RFP question and including a will comply statement within the body of the narrative.

Attachment 1 requirement	Cross-reference to Attachment 5	Will comply
12.1 General Expectations	Attachment 5, Question 1	Yes
12.2 Program Integrity Plan	Attachment 5, Question 1	Yes
12.2.1 Plan Contents	Attachment 5, Question 1	Yes
12.2.1.1	Attachment 5, Question 1	Yes
12.2.1.2	Attachment 5, Question 1	Yes
12.2.1.3	Attachment 5, Question 1	Yes
12.2.1.4	Attachment 5, Questions 1,3	Yes
12.2.1.5	Attachment 5, Question 1	Yes
12.2.1.6	Attachment 5, Question 1	Yes
12.2.1.7	Attachment 5, Question 1	Yes
12.2.1.8	Attachment 5, Question 1	Yes
12.2.1.9	Attachment 5, Question 1	Yes
12.2.1.10	--	Yes
12.2.1.11	--	Yes
12.2.1.12	--	Yes
12.2.1.13	--	Yes
12.3 Required Fraud and Abuse Activities	Attachment 5, Questions 1,2,3,4	Yes
12.3.1 Activities	Attachment 5, Questions 1,2,3,4	Yes
12.3.1.1	Attachment 5, Question 4	Yes
12.3.1.2	Attachment 5, Question 4	Yes
12.3.1.3	Attachment 5, Question 3	Yes
12.3.1.4	Attachment 5, Question 4	Yes
12.3.1.5	Attachment 5, Question 1	Yes
12.3.1.6	Attachment 5, Question 3	Yes
12.3.1.7	Attachment 5, Question 1	Yes
12.3.1.8	--	Yes
12.3.1.9	Attachment 5, Question 2	Yes

Attachment 1 requirement	Cross-reference to Attachment 5	Will comply
12.3.1.10	--	Yes
12.4 Reporting Fraud and Abuse	Attachment 5, Question 1	Yes
12.5 Coordination of Program Integrity Efforts	Attachment 5, Question 1	Yes
12.5.1 Minimum Requirements	Attachment 5, Question 1	Yes
12.5.1.1	Attachment 5, Question 1	Yes
12.5.1.2	Attachment 5, Question 1	Yes
12.5.1.3	Attachment 5, Question 1	Yes
12.5.1.4	Attachment 5, Question 1	Yes
12.5.1.5	Attachment 5, Question 1	Yes
12.5.1.6	Attachment 5, Question 1	Yes
12.6 Verification of Services Provided	Attachment 5, Question 5	Yes
12.7 Obligation to Suspend Payments to Providers	--	Yes
12.7.1	--	Yes
12.7.1.1	--	Yes
12.7.1.2	--	Yes
12.7.1.3	--	Yes
12.7.1.4	--	Yes
12.7.1.4.1	--	Yes
12.7.1.4.2	--	Yes
12.7.1.4.3	--	Yes
12.8 Required Provider Ownership and Control Disclosures	--	Yes
12.9 Contractor Reporting Obligations for Adverse Actions Taken on Provider Applications for Program Integrity Reasons 42 CFR §455.1002.3	--	Yes
12.10 Termination of Providers	--	Yes
12.11 Enforcement of Iowa Medicaid Program Rules	--	Yes

12.1 General expectations

Please explain how you propose to execute Section 12 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

At Aetna Better Health of Iowa Inc. (Aetna Better Health), we are committed to collaborating with state and federal agencies to combat Medicaid fraud, waste, and abuse (FWA). In this section, we will detail how our staff audits claims, identifies potential overpayments, and educates members and providers on their role in prevention.

A respected national leader in program integrity

Aetna has made tremendous contributions to the field of FWA.

- Aetna is a development partner of IBM's Fraud and Abuse Management System (FAMS). The hospital module has identified more than 200 facilities with questionable outlier behavior representing $20 million in potential recoveries.
- Aetna is a founding member of the National Health Care Anti-Fraud Association (NHCAA), the leading national organization focused exclusively on the fight against health fraud.
- Aetna is a founding member of the Medical Identity Fraud Alliance, the first public/private cooperative specifically uniting all stakeholders in jointly developing solutions and best practices for the prevention, detection, and remediation of medical identity fraud.
- Aetna is a member of Centers for Medicare and Medicaid Services (CMS) Health Care Fraud Prevention Partnership (HFPP), a voluntary public/private partnership between the federal government, State officials, law enforcement, private health insurance plans and associations, and health care anti-fraud associations. The HFPP focuses on data sharing and analytics, plus training, outreach, education and information sharing.
- Aetna is a member of CMS Healthcare Anti-Fraud Task Force.

Bringing our proven fraud, waste, and abuse solutions to Iowa

Local Based Plan Our Iowa-based Program Integrity Manager (PIM) will lead program integrity efforts, reporting directly to our Iowa Aetna Better Health CEO.

The PIM will oversee the Iowa-based Program Integrity Unit (PIU) that will be responsible for coordinating and collaborating review and investigation of fraud and abuse (FA) issues. The PIM will have open and immediate access to all of Aetna's Special Investigations Unit's (SIU) leadership, tools, and supports—meeting all Agency requirements. We outline the PIM's detailed roles and responsibilities in our response to Section 12, Question 1 of Attachment 5.

In 2014, Aetna helped Iowa state prosecutors and the FBI investigate and successfully convict Angela Shae Ellison of the Cornerstone Counseling Center based in Centerville, Iowa. Ellison admitted instructing her employees to submit over 6,000 false claims to insurers for services that were not provided. She was sentenced to jail and ordered to pay $724,359 in restitution.

Figure 12-1: [redacted] CONFIDENTIAL

[redacted]

Throughout our response, we will demonstrate how we focus on proactive detection of FWA, including:

- **Staffing and governance** – Creating an environment that encourages collaboration and cross training. Establishing and maintaining an effective system of resolving and escalating issues.
- **Policies, procedures, and Code of Conduct** – Maintaining clear policies and procedures that address the risks. Maintaining a Code of Conduct to inform all staff of their responsibilities. Developing oversight and monitoring programs to make certain that staff adheres to our policies, procedures, and Code of Conduct.
- **Training and education** – Creating and delivering effective and meaningful training programs to all staff about the compliance responsibilities related to their jobs.
- **Communication –** Strengthening our business culture by communicating our values and policies in a targeted and meaningful way that engages all staff.
- **System for routine monitoring and identification of risk** – Establishing and maintaining easily accessible systems for staff to interact with Compliance and management so they can ask questions and raise concerns. Developing and coordinating a Compliance (Program Integrity) Plan to review our key business activities our Internal Audit teams. Following state and federal laws, policies, procedures, Following the Code of Conduct for Aetna, our parent company.
- **Disciplinary standards** – Publishing disciplinary standards and our Code of Conduct on the Aetna Medicaid intranet site and the Compliance and Regulatory Affairs home page. Communicating standards during town halls, team meetings, and through established printed communication.
- **Procedures and systems for prompt reporting** – Maintaining and communicating clear, objective, and efficient systems, training, and tools for the investigation of suspected compliance violations. Applying fair and consistent discipline for compliance violations.

We will maintain strict due diligence when seeking out potential FA. We will have an action plan to investigate suspected FA by staff, subcontractors, providers, or others with whom we do business. We

will provide our policies and procedures to the Iowa Department of Human Services (the Agency). We will cooperate with the Agency, providing data, and communicating regularly.

We will maintain a Program Integrity Plan that includes the requirements listed in the Contract and pursuant to 42 CFR §438.608 and 42 CFR §455. The plan will be effective immediately after Contract execution between the Agency and Aetna Better Health.

Attachment 5 – Section 12, Question 1 [SOW 12.1, 12.2, 12.2.1.1 to 12.2.1.13, 12.3.1.7, 12.4, 12.5, 12.5.1-12.5.6]

Describe your procedures for avoiding, detecting, and reporting suspected fraud and abuse to the State

The role of the Program Integrity Manager

Working closely with Iowa Medicaid Enterprise (IME), the Department of Public Health (DPH), Iowa's Medicaid Fraud Control Unit (MFCU), and Aetna Medicaid's SIU, the PIM is responsible for:

- Program oversight and management
- Communications with IME, MFCU, and the Office of the Attorney General
- Development and operations of a fraud control program within the claims payment system
- Coordination of internal and external initiatives relative to program integrity

"What keeps me up at night?

This question always seems to come back to concerns about what new fraud opportunities could emerge as a result of the Affordable Care Act. IDENTITY THEFT and IDENTITY LOANING, as well as enrollment fraud, are two challenges that I think we are going to be confronted with in the very near future. It is imperative that we work with our internal business partners such as our enrollment group, provider data services, contracting, and others so that we can put up the best defenses possible."

Ralph Carpenter, Director of Aetna SIU and current Chair of Board of Directors of NHCAA

Fraud and Abuse Investigators

Our Iowa-based FA Investigators' responsibilities will include:

- Conducting investigations of known or suspected acts of health care fraud and abuse
- Communicating and cooperating with federal, state, and local law enforcement agencies as appropriate in matters about the prosecution of specific health care fraud cases
- Investigating to prevent payment of fraudulent claims committed by members or providers
- Recovering monies lost as a result of fraud
- Providing input regarding controls for monitoring fraud-related issues within the business units
- Delivering educational programs designed to promote fraud deterrence and detection
- Researching and preparing cases for clinical and legal review; documenting case activity in the tracking system; making internal and external referrals in the required timeframes

Avoiding and detecting fraud and abuse

We will use a variety of technologies to detect questionable billing practices and avoid fraudulent claims payments. We will use business intelligence software to identify providers whose billing, treatment, or patient demographic profiles differ significantly from those of their peers. Please see Appendix O Program Integrity Plan.

Our SIU's primary detection tool is the IBM FAMS. While only the Aetna Medicaid SIU staff will work on Medicaid cases, SIU staff who monitor commercial and Medicare lines of business will also be available to provide guidance and expertise on the best way to pursue an investigation, creating an internally specialized investigative organization. For example, if a provider is improperly billing claims in Medicare, the SIU has a process in place to check all lines of business for the same allegation—including Medicaid. This process allows us to ***review the allegations we receive through data mining and gives us additional leads*** that may not have otherwise been found.

FAMS models provider behavior and identifies outliers based on elements chosen from a library of over 8,000 discrete or custom measures built by Aetna's SIU technology staff.

Additionally, our SIU's Internal Analytics staff runs case- and scheme-specific reports using Structured Query Language, Statistical Analysis System software, and Crystal reporting technology to support current investigations and identify new cases.

FAMS has helped identify more than 200 facilities with questionable outlier behaviors, representing $20 million in potential recoveries.

Iowa Program Integrity staff will assist Aetna Medicaid's SIU in developing a checklist of the signs and signals of FA. The staff will also help interpret clinical case-related data. Examples of areas we proactively investigate as a team include:

- Discrepancies between the submitted diagnosis and treatment
- Claims that are resubmitted with coding changes to gain benefits, or alterations on claims submissions
- Medical necessity of services rendered
- High volume or high percentage of dollars paid in one or two procedures
- Pressure for quick claim payment
- Providers using a post office box as service address

The prevention technique known as ***"Provider Watch" places an alert on a provider's file***. This alert directs workflow, routing, and review of provider billings that have an elevated fraud risk. We flag provider records when we require a closer review of a provider's billings for potential for FA. Provider flags trigger actions during claims adjudication. These actions vary from full auto-denial to a referral for pre-payment review.

Additional mechanisms to ***proactively identify instances of FA*** include:

- Accepting referrals of suspected FA by members, providers, and other internal departments
- Receiving case referrals from federal or state law enforcement and state regulatory agencies, such as the U.S. Department of Health and Human Services at the Office of Inspector General and Iowa Department of Human Services
- Monitoring national trends and specific case referrals through Aetna affiliations with national industry groups, including the NHCAA
- Maintaining a toll-free 24-hour telephone hotline for reports of actual or suspected FA
- Maintaining an e-mail address for members and providers to report fraud and abuse at www.aetnabetterhealth/iowa.com

Moving swiftly to gather and investigate suspected cases of fraud and abuse

Local Program Integrity staff will work closely with Aetna SIU staff in the investigative process.

We will enter all relevant information into the SIU case-tracking database. The database documents the time from receipt to closure. A typical loading process includes preliminary investigative steps, such as the validation or verification of the provider's tax identification number and member name and evaluation of the referral to determine the merits or substance of the referral. Steps include:

- A review of all submitted documents for potential fraud indicators, provider claims history, provider prior authorization history, or member grievance records, as appropriate
- Identification of additional information needed to properly evaluate the referral, such as medical records for billed charges on specific dates of services
- Determination of whether the referral warrants additional investigation depending on findings after initial evaluation

The Investigator updates the referral in the SIU case-tracking database and creates an electronic case file on the SIU secure hard drive to store documentation. The database allows easy access to all case files and contains pre-programmed reporting to track and manage the investigations.

Reporting fraud and abuse to the Agency

We will cooperate and collaborate with the Agency on taking corrective action on detected or suspected FA. Per Section 12.4, we will submit documentation of the findings of the investigation to the Agency within two days of identification.

We will closely work IME, DPH, and MFCU staff on all program integrity efforts.

Our PIM will be the liaison for the Scope of Work described below. We will perform the duties outlined from Section 12.5.1.1 through 12.5.1.6, such as monthly meetings, provision of required documentation and reporting of FA within two working days. We will provide the Agency and the MFCU with an annual update of investigative activity, including corrective actions taken. We will ***coordinate program integrity activities as required by the Agency as part of our Program Integrity Plan.***

In the reports we submit, we will provide the number of FA complaints that warrant preliminary investigation. For each complaint that warrants investigation, we will report the following information:

- Name and ID number
- Source of complaint
- Type of provider
- Nature of complaint
- Approximate dollars involved
- Disposition of the case
- Service type

Every month, we will provide a program integrity activity report to the Agency that will include the following:

- The name and national provider identifier (NPI) of provider reviewed
- The reason for the review, including data source or referral
- Review outcome
- Provider referrals to MFCU
- Providers suspended – reason for suspension
- Providers terminated – reason for termination
- Provider recoupment amount – reason for recoupment
- Provider payment reductions – reason for payment reduction
- Providers who were denied enrollment or re-enrollment pursuant to 42 CFR §455, including name, NPI, and reason for denial

- State fiscal year to date summary information of Contractor program integrity activity

Attachment 5 – Section 12, Question 2 [SOW 12.3.1.9]

Provide examples of outcomes achieved in other states regarding program integrity efforts.

Best practices lead to successful outcomes

Table 12-1 provides success stories that are the result of our best practices described in this section.

Table 12-1: Summary of fraud detection success stories from our health plans

State	Success story	Role of health plans or Aetna SIU	Outcome/monies recovered
Iowa (2014)	Angela Shae Ellison, a nurse and operator of Cornerstone Counseling Center in Centerville, Iowa, instructed her employees to submit over 6,000 false claims to insurers for services that had not been provided. Ellison admitted that she billed Medicaid and private insurers for visits with physicians even though they never treated her clients.	We collaborated with state prosecutors and federal authorities during the investigation.	Ellison was sentenced to serve 366 days in prison and pay restitution of $724,359 for health care fraud.
Arizona (2014)	Dr. Sayegh was found to have violated state law by forging prescriptions to controlled substances to patients.	We collaborated with Office of Inspector General (OIG) by providing medical records to investigate this matter.	Dr. Sayegh's medical license was suspended and he was terminated from the health plan.
Delaware (2013)	In April 2013, a member's mother called our hotline to report she received a verification letter regarding services that had been rendered for her son by counselor Rosa M. Fernandez. The mother stated that her son has not been receiving services from this provider for over two years.	Our Program Integrity staff reviewed additional dates of service and determined a total of 40 dates of billed services that were not rendered to her son. They reported this to the Aetna SIU further investigation. The plan and SIU collaborated with the state and local officials for further investigation.	The SIU investigation completed their review and identified an overpayment in the amount of $202,897.42. Both Fernandez and her assistant have been convicted of Medicaid fraud.
Texas	The SIU identified several providers billing newborn hearing screenings using Current Procedural Technology (CPT) codes 92587 and 92586. Per Texas Medicaid policy, the case rate is paid to the facility for mother or infant and no additional reimbursement is allowed.	The Texas plan implemented a system edit to deny claims billed separately from the facility rate.	Due to the system edit, the plan recovered more than $800,000 and avoided $500,000 in costs.

Attachment 5 – Section 12, Question 3 [SOW 12.2.1.4, 12.3.1.1, 12.3.1.2, 12.3.1.3, 12.3.1.4, 12.3.1.6]

Describe methods for educating employees, network providers and members on fraud and abuse identification and reporting.

Fraud and abuse identification ad reporting through education, outreach, and hotlines

We provide education and outreach for staff, providers, and members across all lines of business, and we will continue to do so in Iowa. With many potential members and providers in Iowa unfamiliar with Medicaid, our efforts will focus on billing procedures, service verification, and available resources to report suspected FWA.

Quality and Value through Simple, Relevant Solutions

We make it easy for staff, providers, and members to report suspected FA by calling our compliance hotline—a toll-free number prominently featured on Member Explanation of Benefits documents and Provider Remittance Advices. Our website will also offer members and providers additional details on identifying and reporting FA.

Staff education

We will provide initial and ongoing fraud awareness training for Claims Processors, Member Service Representatives, Underwriters, Provider Services Representatives, and other Aetna Better Health field staff. Our web-based training focuses on fraud awareness, detection, reporting, and Agency reporting mandates. Our staff across all levels of the organization are trained, expected, and required to comply with all provisions of our compliance program including, but not limited to, FA. Our ***staff must complete compliance training program upon hire, annually, and on an ad hoc basis*** as needed. FA training topics include, but are not limited to, the following:

- Aetna Better Health's commitment to compliance, including Health Insurance Portability and Accountability Act (HIPAA) requirements
- Our Code of Conduct for staff in preventing, reducing, detecting, correcting, and reporting FA violations
- Prevention, detection, and reporting of known or suspected FA through:
  - Our PIM
  - Our 24 hour, toll-free number for reporting
  - The Medicaid fraud hotline toll-free number for reporting
  - The Aetna Better Health (PIU) for reporting via telephonic and written correspondence
  - Corrective action guidelines
- Deficit Reduction Act of 2005 and Federal False Claim Act provisions
- Confidentiality and non-retaliation protections

Upon completion of initial and ongoing compliance training, our staff acknowledge they participated in the training, understood the information we provided, and will adhere to compliance program requirements.

Provider education

Our providers and staff play an important part in helping to prevent, detect, and report instances of FA. Our new providers will receive in-depth training on all aspects of FA and use of compliant billing procedures to reduce instances of suspicious claims. We will reinforce this training through our ongoing annual provider forums and our newsletter. Providers will be able to access ***information on our provider portal regarding their responsibilities to report FA***. Our FA provider training will include:

- Our commitment to compliance, including HIPAA requirements
- Standard of Conduct for providers in preventing, identifying, and reporting compliance violations
- Deficit Reduction Act of 2005 and Federal False Claims Act provisions
- Confidentiality and non-retaliation protections
- Prevention, identification, and reporting of known or suspected FA, including the availability of:
  - Aetna Better Health's PIM's contact information
  - Our 24-hour, toll-free number for reporting by telephone
  - The Medicaid fraud hotline toll-free number for reporting by telephone
  - Aetna Better Health PIU contact information for telephonic and written correspondence
  - Corrective action guidelines

Our provider contracts will contain language that requires providers to follow our FA policies and procedures. ***Providers must follow Agency requirements regarding FA as a condition of payment.*** Our Provider Services Department will conduct regular communication onsite and by telephone with contracted and non-contracted providers. These communications will include information on appropriate claims submission requirements, coding updates, electronic claims transactions, and electronic fund transfers. Communication will be tailored to provider-specific issues.

Member education

Our member handbook and our website serve as one of the main sources for communicating the details of the Program Integrity Plan to our members. Our ***member handbook and website provide information on types of FA*** including member ID card fraud, Emergency Department abuse, and prescription drug misuse or abuse. These also educate members on their responsibilities, the responsibilities of others, the definition of FA, and how and where to report suspected or known FA by contacting:

- Our PIM
- Our 24 hour, toll-free number by telephone
- The Medicaid fraud hotline toll-free number to report by telephone
- The Aetna Better Health PIU in writing or by telephone

Our Case Managers have direct contact with our members and are responsible for providing information to our members and members' families and caregivers regarding the process for detecting and reporting potential FA as needed. Periodically, our quarterly member newsletters will include articles on member ID card fraud and other FA concerns. These articles will provide additional examples of behaviors to watch for and emphasize our members' responsibility to report potential FA.

Vendors and subcontractors

Vendors and subcontractors will be able to report suspected FA by contacting us following the instructions in the FA training materials and information located on our website. The Compliance staff routes referrals to the SIU and reports suspected cases to the Agency. We will ***discuss FA with***

subcontractors periodically at subcontractor oversight meetings. We will emphasize the requirement to report all suspected fraud cases within 24 hours. Depending on which services we delegate to the subcontractor, either Aetna Medicaid SIU or the subcontractor will conduct the investigation and report findings to our Compliance Committee.

Attachment 5 – Section 12, Question 4 [SOW 12.3.1.1, 12.3.1.2, 12.3.1.4]

Describe internal controls to ensure claims are submitted and payments are made properly.

Appropriate claims editing stops inappropriate billing

We will use claims editing software so that professional claims reaching an adjudicated status of "Pay" are automatically reviewed against nationally recognized standards, such as the Correct Coding Initiative (CCI). These system capabilities use historical claims information to detect and correct questionable billing practices and assist in identifying fraudulent and abusive patterns. These professional claims CCI control edits include:

- **Member eligibility –** The adjudication system validates the date of service against the member's enrollment. If the member is not eligible on the date of service, the system will automatically deny the claim using the appropriate HIPAA-approved remittance comment.
- **Covered or non-covered services –** If services are not covered, the system will automatically deny that claim line. If the services are up-coded or unbundled, the system sends a recommendation to deny the claim line with the specific reason.
- **Services within the scope of the network provider's practice –** The system allows certain procedures to be performed only by selected network provider types. The system also reviews claims lines that are set to pay for network provider billing appropriateness by specialty.
- **Duplication of services –** The system has a comprehensive set of edits to determine duplication of services using criteria such as member, date, network provider, service, or a combination.
- **Prior authorization –** The system has a separate configuration for prior authorization templates and associated service groups. Claims edit rules will validate the claim against the network provider, member, dates of service, services rendered, and units authorized.
- **Invalid procedure codes –** We configure files annually for procedure code using HIPAA standards. If a network provider bills a terminated code, the system will deny the claim line and advise the network provider the code is invalid.
- **Other edits** – The system checks for data accuracy, over-utilization standards, and durable medical equipment.

In addition, the claims adjudication system has edits in place to hold claims for manual review and generates daily reports of such claims. We also perform periodic review of closed claims. We will establish policy and procedures to attest to the accuracy, completeness, and truthfulness of claims and payment data per 42 CFR §457.950(a)(2).

Attachment 5 – Section 12, Question 5 [SOW 12.6]

Describe methods for verifying whether services reimbursed were actually furnished to members as billed by providers.

The process for verifying member service

As noted above in Question 2, our member verification letters and follow-up process continues to be one of the best ways we learn about potential billing fraud.

We will mail member verification notices each month to a random sampling of members to confirm whether they have received services from the provider listed on the notice. We take a statistically valid member sample from both professional and institutional claims using a stratified sampling methodology at a 95% confidence interval and 10% precision. This confidence interval means there is a 95% probability with a margin of error of ± 5% that the sample represents the full claims population. The sample size for a given month depends upon the total claims volume and dollar amount for that month. The sample run will occur no later than the 10th of each month.

Member verification notice and toll-free hotline

The member verification notice will ask the member to call a toll-free hotline if the provider named on the member verification notice did not provide services. An FA Analyst answers each call to the hotline and then researches, documents, and refers the case to the FA Investigator, as necessary. The FA Investigator will examine the referred case and forward the findings to our PIM. We will use First Class postage to mail member verification notices and request a return receipt.

12.3 Required fraud and abuse activities

The Contractor must conduct, at minimum, the following fraud and abuse activities:

Developing procedures to monitor utilization/service patterns of providers, subcontractors, and members including but not limited to running algorithms on claims, predictive analytics, and trending claims behavior and recover improper payments identified by this monitoring;

Our procedures to monitor utilization and service patterns

The PIM will collect and analyze information from various departments within our organization to monitor and identify potential compliance violations. The following departments play a key role in identifying variances in utilization and service patterns that could indicate fraud or abuse:

- **Medical Management –** As the first line of defense, Medical Management activities will verify member eligibility, review medical necessity, determine appropriateness of authorizations, verify covered services, and refer members to appropriate providers. The reports may highlight unusual patterns, indicating potential fraud or abuse.
- **Provider Services and Quality Management –** We will train Provider Services and Quality Management staff to be aware of probable FA indicators so that issues may be identified during routine office visits. Either Provider Services Representatives (during routine office visits) or the Quality Management staff (during a provider ambulatory medical records review), may identify care rendered by an unlicensed person in a provider's office or a member obtaining Agency services illegally.

- **Member Services –** The Member Services Department will track and document member complaints, grievances, and appeals (including member survey results) to identify potential trends or patterns of fraud.
- **Network Development –** Network Development staff will conduct provider credential validation to prevent contracting with providers previously convicted of fraud or abuse. We will validate the credentials of all providers following NCQA criteria, as well as state and federal standards. As part of this process, we will collect and evaluate information about providers from a variety of sources, such as the National Practitioners Data Bank, the OIG List of Excluded Individuals or Entities, the System of Award Management, and other sites as may be determined by the Agency.
- **Program Integrity –** We will conduct statistically valid random audits routinely and periodically to detect fraudulent billing. Audit findings will be provided to the PIM for review and action. At a minimum, the audit will verify:
  - The provider was allowed to provide the billed service
  - The appropriate level of care was provided
  - The appropriate billing was performed
  - The charges were reasonable
  - There is no evidence of excessive testing or referrals

Criteria for high-risk services and providers

We will perform in-depth reviews of services and providers we consider to be high-risk. Each quarter, we will generate a separate member verification sampling by provider type for categories such as Behavioral Health, Long-term Care, Durable Medical Equipment, Orthotics and Prosthetics, and Home Health. If the Agency has special requests, we can perform an additional member verification sampling by specific NPI. Our Provider Services team will conduct announced visits to provider offices to review new initiatives or program offerings for our members or providers. We will also make unannounced visits if there is a grievance about the provider or their office setting. We will use this time to validate the grievance and to determine any next steps.

Our Utilization Management staff play a key role to identify patterns and trends

Our Utilization Management (UM) reports will provide a comprehensive framework to examine utilization patterns and trends. We will institute a weekly cross-functional UM workgroup that will include includes staff from Finance, Operations, Medical Management, Care Management, and other areas as necessary. Our UM Medical Director will review data from these reports. The goal will be to analyze utilization data to identify over- and under-utilization of services and unexpected trends.

Examples of reports that will help identify patterns and trends include certain categories of expense, CORE, provider profiling, pharmacy utilization, Emergency Department utilization, and cost reports. The provider profile reports will help identify primary care provider (PCP) and high-volume specialist utilization patterns that vary significantly from peer network provider groups. They also provide information to network PCP and high-volume specialists about their practice patterns.

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Section 13: Information Technology

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SECTION 13 – INFORMATION TECHNOLOGY

The table below outlines how the Scope of Work provided in RFP Attachment 1 relates to the responses to the questions provided in RFP Attachment 5. We provide this table to reduce redundancy of responses and information and to simplify the evaluation process for the evaluators.

For requirements in Attachment 1 that do not require a detailed response, the table below indicates our intent to comply with the stated requirement in lieu of repeating the RFP question and including a will comply statement within the body of the narrative.

Attachment 1 requirement	Cross reference to Attachment 5	Will comply
13.1 Information Services & System	Attachment 5 – Section 13.1, Question 1	Yes
13.1.1 Required Functions	Attachment 5 – Section 13.1, Question 1	Yes
13.1.1.1 Member Database	Attachment 5 – Section 13.1, Question 1	Yes
13.1.1.2 County of Legal Residency	Attachment 5 – Section 13.1, Question 1	Yes
13.1.1.3 Clinical Information	Attachment 5 – Section 13.1, Question 1	Yes
13.1.1.4 Reporting	Attachment 5 – Section 13.1, Question 1	Yes
13.1.1.5 Claims Processing	Attachment 5 – Section 13.1, Question 1	Yes
13.1.1.6 Medication Management	Attachment 5 – Section 13.1, Question 1	Yes
13.1.1.7 Capitation Payment	Attachment 5 – Section 13.1, Question 1	Yes
13.1.1.8 Incurred Claims	--	Yes
13.1.1.9 Third Party Liability	--	Yes
13.1.1.10 Claims Processing Timeliness	--	Yes
13.1.1.11 Critical Incident Data	--	Yes
13.1.1.12 Clinical Data	--	Yes
13.1.1.13 Grievance and Appeals	--	Yes
13.1.1.14 Utilization Management	--	Yes
13.1.1.15 Ad Hoc Reporting	--	Yes
13.1.1.16 Service Referrals	--	Yes
13.1.1.17 Service Specific Information	--	Yes
13.1.1.18 Age Specific Information	--	Yes
13.1.1.19 Encounter Data	--	Yes
13.1.2 General Systems Requirements	--	Yes
13.1.2.1 Edits, Audits and Error Tracking	Attachment 5 – Section 13.4, Question 4	Yes
13.1.2.2 System Controls and Balancing	Attachment 5 – Section 13.1, Question 1	Yes
13.1.2.3 Back-Up of Processing and Transaction Files	Attachment 5 – Section 13.1, Question 2	Yes
13.1.3 Data Usage	--	Yes
13.1.3.1 Data Management	Attachment 5 – Section 13.1, Question 3	Yes

Attachment 1 requirement	Cross reference to Attachment 5	Will comply
13.1.3.2 Data Accessibility	--	Yes
13.1.4 System Adaptability	Attachment 5 – Section 13.1, Question 1	Yes
13.1.5 Information System Plan	Attachment 5 – Section 13.1, Question 4	Yes
13.1.5.1	Attachment 5 – Section 13.1, Question 11	Yes
13.1.5.2	Attachment 5 – Section 13.1, Question 11	Yes
13.1.5.3	Attachment 5 – Section 13.1, Question 11	Yes
13.1.5.4	Attachment 5 – Section 13.1, Question 11	Yes
13.1.5.5	Attachment 5 – Section 13.1, Question 5	Yes
13.1.5.6	Attachment 5 – Section 13.1, Question 6	Yes
13.1.5.7	Attachment 5 – Section 13.1, Question 6	Yes
13.1.6 IS Staff	Attachment 5 – Section 13.1, Question 5	Yes
13.1.7 HIPAA Compliance	Attachment 5 – Section 13.1, Question 6	Yes
13.1.8 Electronic Mail Encryption	--	Yes
13.1.9 Interface with State Systems	Attachment 5 – Section 13.1, Question 1	Yes
13.1.9.1 The Agency MMIS	Attachment 5 – Section 13.1, Question 1	Yes
13.1.9.2 The Agency Title XIX Eligibility System	Attachment 5 – Section 13.1, Question 1	Yes
13.1.9.3 IDPH Data System	Attachment 5 – Section 13.1, Question 1	Yes
13.1.10 Use of Common Identifier	--	Yes
13.1.11 Electronic Case Management System	Attachment 5 – Section 13.1, Question 9	Yes
13.1.12 Electronic Visit Verification System	Attachment 5 – Section 13.1, Question 8	Yes
13.1.13 Clinical Records	Attachment 5 – Section 13.1, Question 9	Yes
13.1.13.1 Diagnosis	Attachment 5 – Section 13.1, Question 9	Yes
13.1.13.2 Level of Functioning	Attachment 5 – Section 13.1, Question 9	Yes
13.1.13.3 Services Authorized	Attachment 5 – Section 13.1, Question 9	Yes
13.1.13.4 Services Denied	Attachment 5 – Section 13.1, Question 9	Yes
13.1.13.5 Missed Appointments	Attachment 5 – Section 13.1, Question 9	Yes
13.1.13.6 Emergency Room	Attachment 5 – Section 13.1, Question 9	Yes
13.1.13.7 Treatment Planning	Attachment 5 – Section 13.1, Question 9	Yes
13.1.13.8 Medication Management	Attachment 5 – Section 13.1, Question 9	Yes
13.1.13.9 Inpatient Data	Attachment 5 – Section 13.1, Question 9	Yes
13.1.13.10 Joint Treatment Planning	Attachment 5 – Section 13.1, Question 9	Yes
13.1.13.11 Discharge Planning	Attachment 5 – Section 13.1, Question 9	Yes
13.1.14 System Problem Resolution	Attachment 5 – Section 13.1, Question 10	Yes
13.1.15 Escalation Procedures	Attachment 5 – Section 13.1, Question 10	Yes

Attachment 1 requirement	Cross reference to Attachment 5	Will comply
13.1.16 Release Management	Attachment 5 – Section 13.1, Question 11	Yes
13.1.17 Environment Management	Attachment 5 – Section 13.1, Question 11	Yes
13.2 Contingency and Continuity Planning	--	Yes
13.2.1 Continuity Planning	Attachment 5 – Section 13.2, Question 1	Yes
13.2.2 General Responsibilities	Attachment 5 – Section 13.2, Question 1	Yes
13.2.2.1	Attachment 5 – Section 13.2, Question 1	Yes
13.2.2.2	Attachment 5 – Section 13.2, Question 1	Yes
13.2.2.3	Attachment 5 – Section 13.2, Question 1	Yes
13.2.2.4	Attachment 5 – Section 13.2, Question 1	Yes
13.2.2.5	Attachment 5 – Section 13.2, Question 1	Yes
13.2.3 IS Contingency Planning and Execution	Attachment 5 – Section 13.2, Question 1	Yes
13.2.4 Back-Up Requirements	Attachment 5 – Section 13.2, Question 1	Yes
13.3 Data Exchange	--	Yes
13.3.1 Member Enrollment Data	Attachment 5 – Section 13.3, Question 1	Yes
13.3.1.1 Member Enrollment Data Exchange	Attachment 5 – Section 13.3, Question 1	Yes
13.3.1.2 Reconciliation Process	Attachment 5 – Section 13.3, Question 1	Yes
13.3.2 Provider Network Data	Attachment 5 – Section 13.3, Question 1	Yes
13.4 Claims Processing	--	Yes
13.4.1 Claims Processing Capability	Attachment 5 – Section 13.4, Question 1	Yes
13.4.2 Claims Disputes	Attachment 5 – Section 13.4, Question 5	Yes
13.4.3 Compliance with State and Federal Claims Processing Regulations	Attachment 5 – Section 13.4, Question 1	Yes
13.4.4 Out-of-Network Claims	--	Yes
13.4.5 Coordination among Contractors	Attachment 5 – Section 13.4, Question 7	Yes
13.4.6 Claims Payment Timeliness	Attachment 5 – Section 13.4, Question 1	Yes
13.4.7 Claims Reprocessing and Adjustments	Attachment 5 – Section 13.4, Question 2	Yes
13.4.8 Member Financial Participation and Cost Sharing	Attachment 5 – Section 13.4, Question 8	Yes
13.4.9 IDPH Prospective Reimbursement	Attachment 5 – Section 13.4, Question 9	Yes
13.4.10 Audit	--	Yes
13.5 Encounter Claim Submission	Attachment 5 – Section 13.5, Question 1	Yes
13.5.1 Definition and Uses of Encounter Claims	Attachment 5 – Section 13.5, Question 1	Yes
13.5.2 Reporting Format and Batch Submission Schedule	Attachment 5 – Section 13.5, Question 1	Yes
13.5.3 Encounter Claims Policies	Attachment 5 – Section 13.5, Question 1	Yes
13.5.3.1 Accuracy of Encounter Claims	Attachment 5 – Section 13.5, Question 1	Yes

Attachment 1 requirement	Cross reference to Attachment 5	Will comply
13.5.3.2 Encounter Data Completeness	Attachment 5 – Section 13.5, Question 1	Yes
13.6 Third Party Liability (TPL) Processing	--	Yes
13.6.1 TPL Responsibility	--	Yes
13.6.1.1 Sources of TPL	Attachment 5 – Section 13.6, Question 2	Yes
13.6.1.2 TPL Data	Attachment 5 – Section 13.6, Question 2	Yes
13.6.2 Cost Avoidance	Attachment 5 – Section 13.6, Question 1	Yes
13.6.2.1 Provider Education	Attachment 5 – Section 13.6, Question 2	Yes
13.6.2.2 Cost Avoidance Requirements	Attachment 5 – Section 13.6, Question 1	Yes
13.6.2.3 Cost Avoidance Exceptions – Pay and Chase Activities	Attachment 5 – Section 13.6, Question 1	Yes
13.6.3 Collection and Reporting	Attachment 5 – Section 13.6, Question 2	Yes
13.6.4 Other Insurance for IDPH Participants	Attachment 5 – Section 13.4, Question 9	Yes
13.6.5 Health Insurance Premium Payment Program	Attachment 5 – Section 13.6, Question 3	Yes
13.7 Health Information Technology	Attachment 5 – Section 13.7, Question 1	Yes

13.1 Information Services and System

Please explain how you propose to execute Section 13 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Aetna Medicaid has the tools and experience to support the Iowa Department of Human Services (the Agency), providers, and the needs of Iowa's vulnerable populations. Our current technological capabilities meet the requirements of the Iowa High Quality Healthcare Initiative (the Initiatives). During the term of the Contract, we will frequently assess the technology we use. We will make upgrades and changes to remain current with evolving technology trends and industry standards.

In this section, we present the information systems Aetna Medicaid will use to process service and utilization data for the Agency. We offer tools and systems to serve the needs of members, providers, and the Agency.

Currently, Aetna Medicaid owns or administers Medicaid managed health care plans that serve nearly 3 million people in 17 states, including Arizona, Florida, Illinois, Iowa (Private Option, part of the Affordable Care Act [ACA] Medicaid Expansion), Kentucky, Louisiana, Maryland, Michigan, Nebraska, New York, Ohio, Pennsylvania, Texas, Virginia, and West Virginia.

In the implementations in those states—particularly the implementations of new systems in Arizona, Illinois, Kentucky, Ohio, and New York—we applied our proven implementation methodology. Both rigorous and flexible to meet the unique needs of any contract, it includes pre-planning, high-level hardware and software capacity planning, resource planning, and system readiness preparation prior to contract award. It creates an infrastructure that both lays the foundation for and expedites subsequent implementation activities.

Attachment 5 – Section 13.1, Question 1

Provide a general systems description and a systems diagram that describes how each component of your information system will support and interface to support program requirements.

Hardware and system architecture specifications

Aetna Medicaid offers an integrated information technology system that includes:

- Production system interoperability
- A business application and data management system at the center of Aetna Medicaid's application architecture
- A comprehensive care management system
- Web functionality including a member portal and a provider portal
- Health information exchange functionality
- [redacted] **- CONFIDENTIAL**
- A reporting engine

We manage Medicaid contract data in Aetna Inc.'s computer centers in Middletown, Connecticut and Windsor, Connecticut. Both facilities have extensive fire suppression systems, dual incoming power feeds, an uninterruptible power supply (UPS), and backup diesel generators supporting 24/7 operation. We control and monitor physical access and segregate access to vital areas by floor and business function.

Figure 13-1 shows our information system structure.

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Figure 13-1: [redacted] **-CONFIDENTIAL**

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Our key business applications run servers based on the Microsoft Windows Server platform. The server configuration provides redundancy and scalability to meet future growth. We can add servers and storage to the cluster to increase overall system capacity as needed. Each server can accept increases in RAM and processing power to provide the benefit of continuous availability. This scalability enables systems to match any escalation in demand associated with performance requirements of Aetna Better Health of Iowa Inc. (Aetna Better Health), while maintaining system uptime and performance.

Production system interoperability

We have established interoperability between the production systems that exchange data. The interfaces provide and accept data feeds between our central claims, eligibility, enrollment, and data processing system, QNXT™, and the surrounding production systems. We use automated batch transfers to update data elements across the production systems at regular intervals. Some cross-system data updates are initiated by system operators to meet production requirements. Figure 13-2 summarizes currently integrated systems.

Figure 13-2: [redacted] **-CONFIDENTIAL**

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The center of our architecture: QNXT™

QNXT™ is our business application and data management system at the center of Aetna Medicaid's application architecture. This rules-based information processing system is built on Microsoft's .NET architecture, which provides a high degree of flexibility, scalability, and integration with other systems. Its database is Microsoft SQL Server. By using this industry standard, relational database management system, we can use a variety of applications to display, print, and analyze data and produce standardized and customized reports. The 28 QNXT™ modules integrate to:

- Adjudicate claims according to benefits package and medical necessity requirements
- Expand to meet changes in covered services or membership
- Manage benefit package differences in category of assistance, program status code, age, and other insurance (for example, Medicare coverage)
- Provide support for all other business applications in care monitoring, delivery, and reporting (for example, wellness, Early and Periodic Screening, Diagnostic, and Treatment[EPSDT])

QNXT™ supports these functionalities through these integrated modules:

- Claims data, including adjudication, payment, coordination of benefits, and third-party liability

- Demographic and enrollment data, including prior coverage data
- Provider contract data, including reimbursement agreements, provider demographics, and contract terms
- Prior authorization and special needs data
- Electronic Data Interchange (EDI)
- Maternity care payments
- Medicaid eligibility records to support utilization management (UM) through prior authorizations and concurrent reviews

The system can configure prior authorization requirements by code, provider type, and place of service, while claim edit rules validate the claim against the network provider, member, dates of service, services rendered, and units authorized.

The engine for our care management programs

Aetna Better Health's care coordination and managed care programs will employ data analytics to focus case management and disease management on those members most at-risk, integrating data from our primary information systems. Our care management system offers the following functionality:

- Captures documentation for health risk screenings, outreach activities, clinical and chronic condition assessments, care plans, long-term services and supports (LTSS) plans, inter-disciplinary care team meetings, care coordination activities, member and provider letters, HIPAA, and releases of information
- Provides web links to applicable resources: community resources, Milliman Chronic Care Guidelines (MCG), Krames educational materials
- Allows Care Management staff to see member specific information, such as when covering for a Case Manager who is not available, when co-managing a member; for example, a member in process of being determined LTSS-eligible and for whom integrated care management (ICM) and LTSS programs are needed
- Offers a variety of reports and queries to monitor individual Care Management staff performance and NCQA compliance for complex care management and chronic condition management, including file audit tools and reports
- Captures data to demonstrate care management program outcomes, including results from health surveys and member satisfaction surveys, as well as successful program completion
- Displays automated prompts to remind staff to complete activities, such as auto-generated tasks, clinically indicated follow-up based on member specific needs, assessment and care plan review reminders
- Accepts data on members who may need outreach for enrollment into care management such as Nurse referrals, high-risk members identified based on predictive modeling, responses to health risk questionnaires and member self-appraisals, members needing post-discharge follow-up
- Allows staff to work in the community, including home visits and when working in remote or rural locations with no Internet connectivity

The window to information: Medicaid web portal

MEMBER WEBSITE AND PORTAL

Our website features information to keep members and caregivers informed of program features and other health-related topics. The website will comply with HIPAA privacy and security requirements and

Section 508 of the Americans with Disabilities Act (ADA). We have optimized our website access for mobile devices such as smartphones. The website member section contains information in Spanish and English. Member features include:

- Provider directory (online searchable tool with sort capability and in PDF format)
- Covered services and benefits
- Complaints and appeals process
- HIPAA Privacy Notice
- Health plan contact information (telephone numbers, addresses)
- Member handbook
- Member community resources
- System downtime information
- Care coordination information

PROVIDER PORTAL

The website also features a provider section with content tailored to their needs. Our secure portal fosters open communication with providers and facilitates access to a variety of information. All information regarding our members, including eligibility or identification information, will be kept secure and HIPAA compliant. To access the secure content, the provider must sign on with a unique user ID and password. Provider portal content includes:

- Provider directory with an online search tool and in PDF format
- Provider manual
- Complaints and appeals process
- Network enrollment information
- Education tools
- Cultural competency information
- Member eligibility inquiries
- Claims status or remittance advice inquiries
- Authorization status inquiries
- FAQs on authorization processes
- Downloadable forms
- Claims appeals and reconsiderations

HEALTH INFORMATION EXCHANGE

The Iowa Health Information Exchange (IHIE) plays a major role in our overall population health management strategy. Timely access to admission, discharge, and transfer (ADT) and other timely clinical data on the Iowa Health Information Exchange, in combination with Aetna Better Health internal data and clinical workflows, can make profound impact on reducing hospital readmissions and Emergency Department (ED) utilization and improving the health of our members. Aetna has a long history of integration with health information exchange (HIE) platforms and fully understands the technology, processes, and requirements.

The Aetna Integrated Care Engine can connect with the Iowa HIE directly via web services and cross-document sharing protocol (XDS.b or XCA). Aetna can also push member eligibility files, provider lists, and other information to identify the right members and providers on the HIE. Through the same bi-directional connection, we can receive ADTs and clinical data to support clinical workflows aimed at improving care transition and minimizing hospital readmissions and ED utilizations. In a situation where the Iowa HIE might not be ready for integration and data exchange with the Aetna Integrated Care Engine, we can receive ADT and other data directly from hospitals as a short-term solution. We will:

- Provide resources and subject matter experts to facilitate integration with Aetna Medicaid systems.
- Enable Aetna Better Health providers in Iowa to access our advanced Population Health Management platform in combination with data from the Iowa HIE. This access will be a significant incentive for providers to join our network.

- Demonstrate the benefits of an ICM model with Iowa HIE to facilitate communication and collaborate and share information among stakeholders
- Train provider staff and Care Team members on how to use Aetna Medicaid tools and applications. There will be no cost to providers for joining the program.
- Evaluate the pilot by obtaining and analyzing feedback from members, providers, Aetna Better Health and Aetna Medicaid staff, and the state of Iowa.

Our mission and tools, combined with the Iowa HIE capabilities will help providers and members be more engaged in producing quality outcomes. Providers who are connected can use our infrastructure for all of our members; our approach is electronic health record (EHR)-agnostic.

We will support, maintain, and update our Population Health Management application infrastructure and connection with the Iowa HIE to proactively manage continuity of care through multiple care settings. In later phases of implementation, we can consume additional relevant data from the Iowa HIE to better manage care for the population, while providing the Iowa HIE additional data to be shared with health care providers.

We can securely exchange data with Iowa HIE using Health Level Seven International® (HL7), web services or document exchange standards. The Aetna Integrated Care Technology platform can also receive and consume HL7 messages and records that have no structured interrelationship ("flat files").

MOBILE APPLICATION (APP)

Pioneer in Fully Integrated Care

To deliver useful information to Iowa members where and when it is needed, we will provide the Aetna Better Health app for both the iOS and Android mobile platforms. According to an IDC report released in August 2014, 96% of smartphones shipped in the second quarter of 2014 used either the Android or iOS platform, making it likely that our members will have a device that can run the app. These platforms support both phone and tablet devices.

Available free from the Apple App Store and Google Play, the bilingual application will include all key functions needed for members. A secure log in protects the user's health information and personal data and unlocks user-specific functions and updates. The app is customized to reflect Iowa benefits.

By delivering a single app, we offer several other benefits:

- **Members need only search for one app for their device.** Other healthcare organizations often have multiple apps available for each market and program, making it harder to know which app to select and install.
- **Just as Iowa will benefit from innovations developed in the future** for other Aetna Medicaid markets, other Aetna Medicaid markets will benefit from innovations developed for Iowa.

We will use our communications with members to encourage them to access their health information through this convenient, portable format. The member handbook and other printed member materials will describe the app and we will promote the app on the publicly accessible part of the Aetna Better Health website. As we make welcome calls and answer member services calls, we will ask members if they know about the app and we explain how to get it, if necessary. Our Community Outreach staff will mention the app when they attend health fairs and other community presentations. Provider Services Representatives will encourage providers to tell their patients who are Aetna Better Health members about the app.

As we continue to develop our mobile application functionality, we will consider how we can offer similar kinds of information access and engagement to other program stakeholders. These stakeholders include providers, caregivers, and Aetna Better Health Care Managers.

APP FUNCTIONS FOR MEMBERS

At the most basic level, we need to give members immediate access to answers for which they might consult a member handbook or provider directory, or for which they would call Member Services. Beyond that, we need to give them relevant and usable information to make wise choices about their healthcare. The Aetna Better Health app will do both. Table 13-1 summarizes the functions we will provide in the app for Iowa, and when those functions will be available.

Table 13-1: Functions of our mobile app to help the member navigate the healthcare system

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The reporting engine

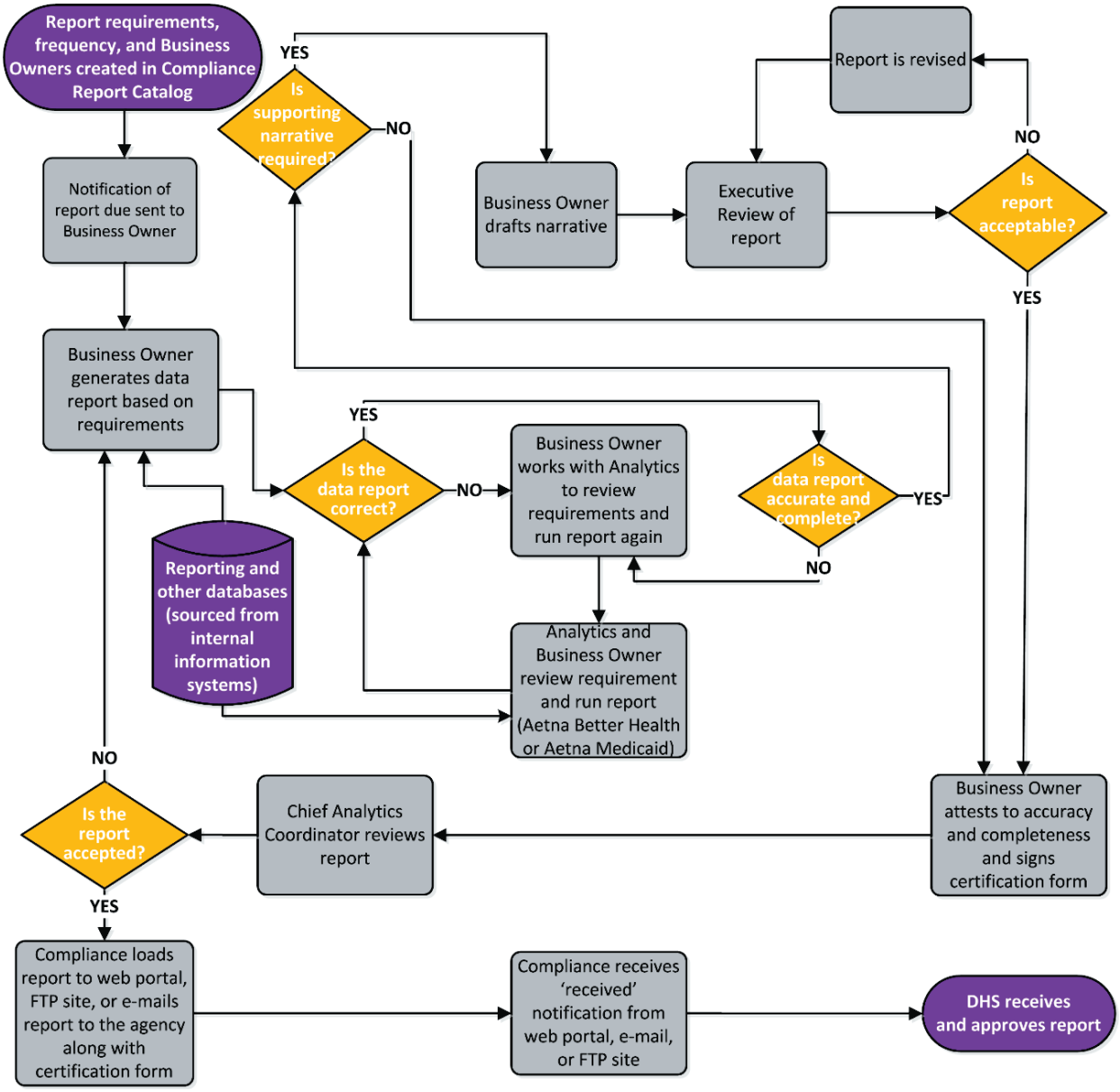
Aetna Better Health will use a variety of internal business tools to produce both internal and external reports. Figure 13-3 shows our current report generation process. Centralizing reporting in this way improves data integrity while providing for complete, accurate, and timely submission of reports. We have cataloged every statutory-, regulatory-, and compliance-based report across the organization; centralized those reports; and standardized each report and its associated metrics to improve data integrity and consistency. The report catalog can identify existing reports that may meet—or meet with minor modification—the requirements of any new health plan, minimizing the need to develop any reports from scratch. A centralized production schedule and quality control process will further support the accurate, complete, and timely submission of required deliverables.

Our primary reporting tool is the Analytical Services Database (ASDB). The ASDB is a comprehensive data warehouse and analytical system. Because this system supports reporting and analysis, such as multidimensional predictive modeling and statistical outlier analysis, we use it as our primary reporting tool. The ASDB contains information received from various applications such as QNXT™ the case management applications, and it serves as a key data source for our diverse user base, including Medical Management, Finance, and Operations staff. We will update pharmacy data from CVS Health (our pharmacy subcontractor) in the ASDB twice monthly to support pharmacy reporting requirements. CVS Health will be able to report pharmacy data directly out of its system.

Aetna Better Health and local Aetna Medicaid analysts use Actuarial Analytics Web Portal, a proprietary Visual Basic interactive interface, as a point-and-click query tool to access reports, navigate data sources, and export information from ASDB.

Our Consolidated Outreach and Risk Evaluation (CORE) predictive model maintains data and produces reports for members needing case management and treatment interventions and assigns risk scoring or rankings that help us identify members at-risk and optimize integrated health care delivery.

Figure 13-3: Report generation process



Attachment 5 – Section 13.1, Question 2

Describe data back-up processing plans including how data is stored at an off-site location.

We manage Medicaid contract data in Aetna Inc.'s data centers in Middletown and Windsor, Connecticut. Both facilities have extensive fire suppression systems, dual incoming power feeds, UPS, and backup diesel generators supporting 24/7 operation. We control and monitor physical access, with access to vital areas segregated by floor and business function.

Data back-up

In the midrange and local area network environments, we perform a full data backup weekly, with nightly incremental backups. For additional redundancy protection, our Database Administrators backup each application database separately. Aetna Medicaid mirrors all mainframe disk and tape data to the alternate data center, providing a simplified and timely recovery in that platform of the environment.

Backup timelines are 24 hours for eligibility verification, enrollment and eligibility update processing, and authorization processing; 72 hours for claims processing; and two weeks for all other processes.

Any customer data lost because of a data center catastrophe can be recovered through resubmittals by service providers and recovery reconciliation teams.

Figure 13-4 summarizes how data is stored at an offsite location.

Figure 13-4: [redacted] **CONFIDENTIAL**

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Attachment 5 – Section 13.1, Question 3

Describe how clinical data received will be used to manage providers, assess care being provided to members, identify new services and implement evidence-based practices.

Utilization management reporting and analytics

We will monitor utilization and performance improvement indicators to track the effective use of clinical resources and services. We will use standard indicators to track utilization fundamentals and will add

others as needed to reflect state regulatory or business requirements; these may include HEDIS or other comparable indicators. The indicators will apply utilization data and information, such as trending reports and data sets, showing over- or under-utilization of resources or identifying specific diseases or large populations with a specific disease.

We will regularly monitor the following performance improvement indicators to assess compliance with established performance standards, including:

- Utilization of services
- Timeliness of utilization decisions and notification to providers and members
- Accuracy in documenting utilization information

Timeliness of referrals to maintain continuity of members' care (for example, for post-discharge services) to obtain assistance in coordinating services (for example, to care management), or to follow up on potential issues (for example, quality, utilization, or risk management referrals). Quarterly, the Utilization Management (UM) Department will evaluate the results of utilization and performance improvement monitoring to identify utilization and performance trends. Operational metrics go to the Service Improvement Committee and clinical metrics go to the Quality Management (QM)/UM Committee. Both the Service Improvement Committee (SIC) and QM/UM report to the Quality Management Oversight Committee (QMOC.) They will also report utilization data and information to select providers. Utilization results are a component of physician quality reports and will be part of standard review during formal quality management processes, such as credentialing and re-credentialing.

Every month, the Medical Director and Director of Medical Management will analyze utilization data, identifying areas of concern in the plan's performance and identifying recommendations for action planning. The Medical Director will present this information to the QM/UM Committee. The QM/UM Committee will then provide feedback to the Medical Director for approval, including adjustments to the Quality Assessment and Performance Improvement program.

SIC metrics for monitoring include:

- Volume of requests received by telephone, facsimile, and website
- Service level
- Timeliness of decisions and notifications
- Process performance rates for the following metrics, using established standards:
  - Telephone abandonment rate under 5%
  - Average telephone answer time within 30 seconds

QM/UM metrics for monitoring include:

- Percentage of prior authorization requests approved
- Trend analysis of prior authorization requests approved
- Percentage of prior authorization requests denied
- Trend analysis of prior authorization requests denied
- Consistency in using criteria in the decision making process among Prior Authorization staff measured by an annual inter-rater reliability audit
- Consistency in documentation by department file audits

We will also monitor the following to identify potential areas of over- or under-utilization of medical inpatient services:

- Bed days per 1,000, monthly
- One-day admissions
- Outlier day reviews
- Member outcomes (re-admissions, with assessment of related discharge planning)
- Consistency of application of medical review criteria as measured through the inter-rater reliability assessment tool
- QM/UM indicators
- Consistency in documentation by department file audits

Provider Quality Performance reports

We will use Provider Quality Performance reports to monitor utilization practices and member health outcomes to identify opportunities for improvement. The objectives of the Provider Quality Management reports are to:

- Identify provider utilization patterns that vary significantly from peer network provider groups
- Identify trends that can be addressed through provider outreach
- Provide information to network providers about their practice patterns
- Safeguard confidentiality by maintaining secure access to the profile interface
- Provide information to be used as a component of quality management oversight and provider incentive compensation

The Medical Management Department will oversee the profiling process, including validation of data reasonableness and activities to monitor use of the reports (for example, site visits, mailings, tracking outcomes over time).

Quarterly, the Medical Director or designee will review utilization patterns, trends, and costs during the previous year. We will distribute the profiles to applicable network providers. If a report reflects practices that do not align with our mission, such as low performance of HEDIS measures, the Medical Director may ask the provider to develop a corrective action plan.

Measuring the effectiveness of guidelines

To assess the effectiveness of the guidelines, we will monitor selected recommended services by providers along with related member outcomes. Our quality committees will evaluate overall performance and assess the need for new programs. We will link the results to individual physician profiles and use these to evaluate over- and under-utilization and determine the need for member and provider education to improve practice patterns. Using guidelines is essential for the development and monitoring of ICM. We will give feedback to providers on individual performance as well as the performance of the Aetna Better Health Plan.

Identification of evidence-based practices

We will make clinical guidelines available to providers and encourage their use to improve the utilization of medications and treatments demonstrated to be effective in treating certain conditions. The clinical guidelines will represent the best practices our health plans use today and are based on national standards, reasonable medical evidence, and expert consensus. Before use, the Chief Medical Officer, applicable medical committees, network physicians, and, if necessary, external consultants will review

and approve the guidelines. We will review guidelines at least every two years or as often as new information is available.

Medical record reviews

The Medical Management Department will screen and review medical documents to identify potential adverse events as well as quality, utilization, safety, or risk issues in the care or services delivered to members. The Medical Management Department will develop indicators for identifying potential over- and under-utilization, including target and performance indicators. The QM/UM Committee must review and approve these indicators before we can apply them. We will require any staff member who perceives a potential quality, risk management, or safety issue to refer the issue to the QM Department. A referral may originate in any Aetna Better Health department, such as Care Management, Utilization Management, Compliance, Grievance and Appeal, or Member Services. That department will document the issue on a Potential Quality of Care (PQoC) Investigation form and forward it to the Quality Management Department for evaluation. QM Nurses may review and assign a different functional area within the organization to review and address the needs as indicated (Grievances and Appeals). The QM staff document and track potential quality of care issues in the PQoC business applications system.

The Chief Medical Officer or designated Medical Director will oversee the peer review investigation of issues referred, following the quality review process that includes:

- Concurrent or retrospective evaluation of medical records to determine the quality of the care and services provided
- Referral of potential issues to the Aetna Credentialing and Performance Committee for review and recommendation
- Notification to the Board of Directors indicating the decision and course of action rendered by the Aetna Credentialing and Performance Committee
- Analysis of identified issues for tracking and trending
- Reporting of findings to designated committees quarterly
- Notification the appropriate regulatory board or agency of provider contract termination, suspension, or limitations due to quality of care issues
- Development and implementation of corrective action plans as necessary
- Provision of Fair Hearing right to providers

The indicators we will use to identify potential quality, risk management, and safety issues are specific to Aetna Better Health and will be approved by the QM/UM Committee and the QMOC.

Attachment 5 – Section 13.1, Question 4

Submit a draft Information Systems Plan as described in Section 13.1.5.

Appendix P is our draft Information Systems Plan for Aetna Better Health. The plan includes:

- Key Information Technology (IT) activities and timeframes
- Projected resource requirements
- Work locations of full-time staff before, during, and after implementation
- HIPAA compliance strategies and timelines

Aetna Medicaid IT staff will be responsible for all tasks under the Information Systems Plan. Aetna Better Health will work closely with the Aetna Medicaid Shared Services functions including the Implementation Project Management Office (PMO), Enrollment, Claims, Medical Management, Clinical,

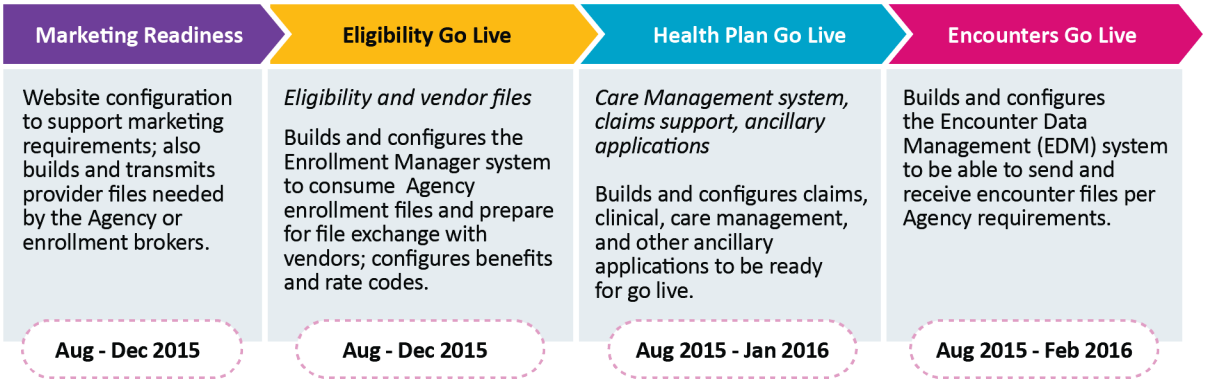
Provider Network, Encounters, and IT to achieve successful execution of the project. Weekly lead team meetings, which have representation from key stakeholders of each function, cover important updates and overall program tracking. Risks and issues that need the Agency's attention will be routed through this meeting where the Aetna Better Health staff would triage and escalate as necessary. We will meet periodically with the Agency and its fiscal intermediaries throughout the course of the Contract (from readiness review all the way to post implementation).

Key IT activities and timeframes

Key IT activities will begin in August 2015 and continue until the end of February 2016. Aetna Medicaid's proposed implementation schedule for the Information Systems Plan provides full conformity with federal and Agency-specific standards. The Aetna Medicaid implementation methodology ensures that all IT projects have the proper level of governance and visibility.

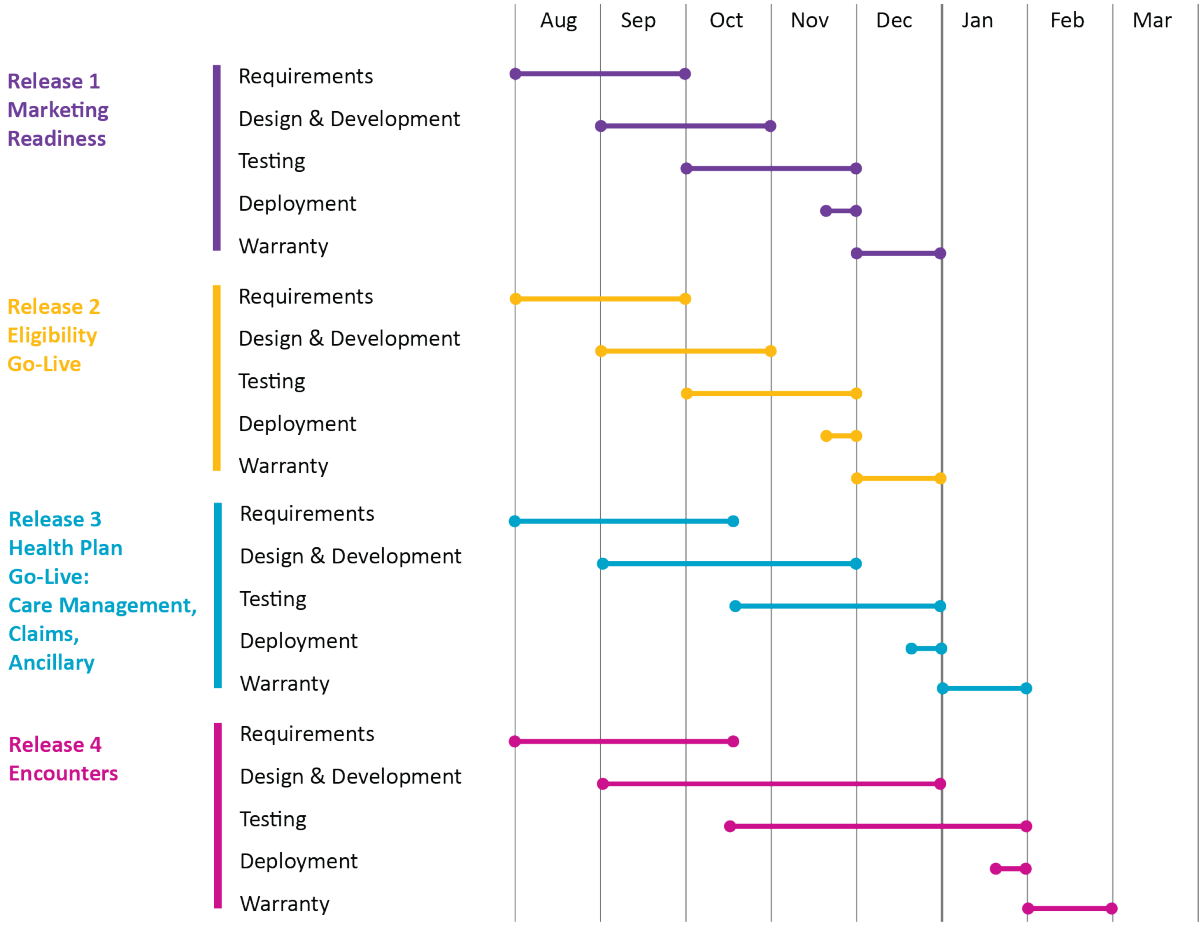
In the Aetna Medicaid implementation methodology, small projects and enhancements will have ad hoc releases, while large project releases are driven by regulatory mandates or business needs. For this implementation, Aetna Medicaid plans to make four major releases to support key systems. Figure 13-5 is a high-level overview of the major releases.

Figure 13-5: Release phases by type



Aetna Medicaid will manage and execute system development and changes through the software development lifecycle as described. There will be a formal approval between each phase for logical progression of the project. Figure 13-6 shows a high-level release schedule based on a go-live date of January 1, 2016.

Figure 13-6: Primary implementation activities will run from August 2015 through February 2016.



Attachment 5 – Section 13.1, Question 5

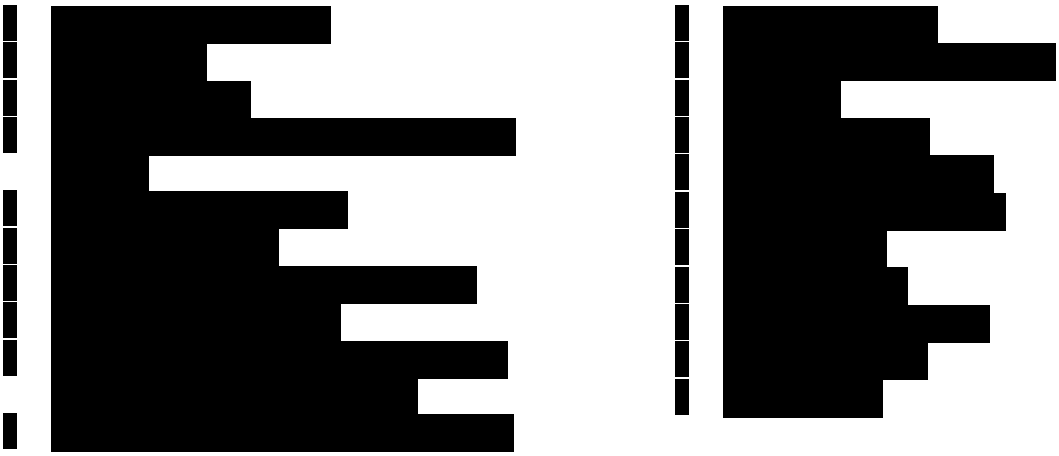
Describe your proposed information systems staffing model.

In the early stages of implementation of the Aetna Better Health information systems for Iowa, the Project Manager and Business Analysts are the primary members of the IT team, while technical team leads participate in business requirements gathering sessions. After the requirements are completed, the design and development team begins constructing the components. The system testing team tests the components when they are complete.

Convening a lead team that includes staff from every operating division, including any division involved in information systems implementation, is one of the first tasks among the preliminary activities.

The lead team will be chaired by [redacted] will be trained and experienced in information systems, data processing, and data reporting to oversee all MCO IT functions, such as establishing and maintaining connectivity with the Agency information systems and providing necessary and timely reports to the Agency. **- CONFIDENTIAL**

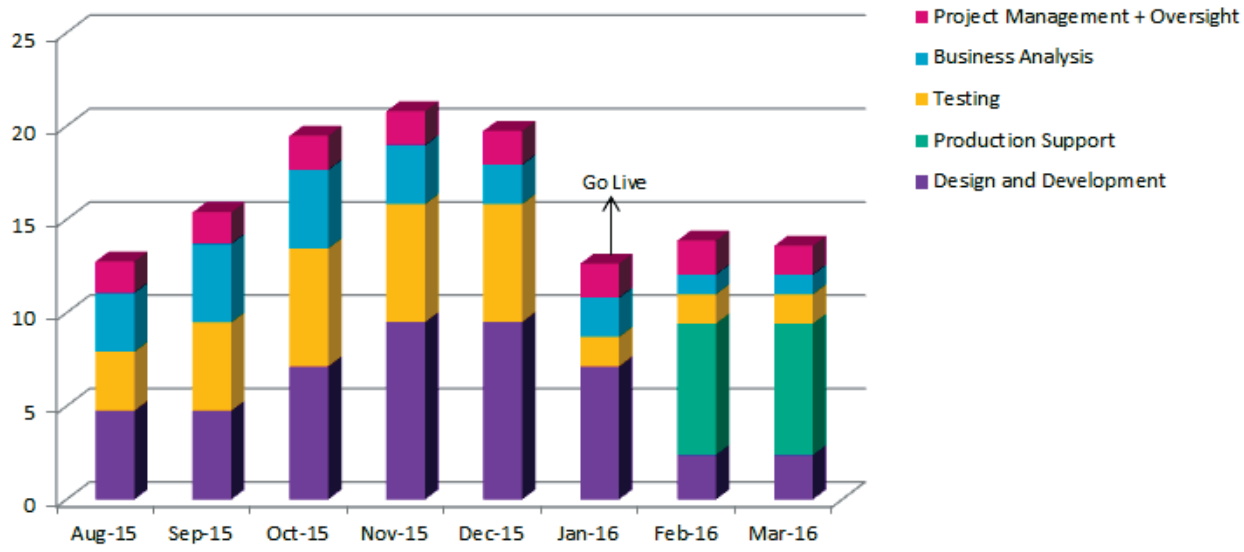
The lead team will include:- **CONFIDENTIAL**



Aetna Medicaid plans to ramp up the technical team as each of the release milestones (Marketing Readiness, Eligibility Go Live, Health Plan Go Live, and Encounters) approaches to make certain that all the components are successfully built, tested, deployed, and supported. The Warranty (post-implementation support) staff will be in place as each milestone is completed and the support phase starts.

Figure 13-7 shows the work balance between key resources throughout the implementation cycle.

Figure 13-7: The work balance between key resources throughout the implementation cycle



Attachment 5 – Section 13.1, Question 6

Describe your plan for creating, accessing, transmitting, and storing health information data files and records in accordance with the Health Insurance Portability and Accountability Act's mandates.

We commit to providing access to best-practice health care for the Agency while protecting the privacy of our members. We comply with both HIPAA and the Health Information Technology for Economic and

Clinical Health (HITECH) act. Our policies, procedures, and safeguards to maintain compliance with HIPAA and HITECH are consistently applied throughout our health plans.

Activities to promote HIPAA compliance

We require providers to submit claims and other HIPAA transactions using the National Provider Identifier (NPI). We monitor claims and other inbound transactions though compliance-checking software used internally and by our designated clearinghouses. Additionally, our staff continues to monitor both Centers for Medicare and Medicaid Services and the industry for any HIPAA transaction or code set developments.

Aetna's EDI Transaction Business team actively participates in industry organizations such as X12, CAQH CORE, WEDI and AHIP from which new or revised requirements for EDI are developed or discussed. The team then coordinates an internal project or program with Regulatory Compliance and HIPAA Legal Counsel, as well as internal development and testing areas, to work through requirements from conception to implementation. Aetna's EDI Transaction Business and Communication teams work together to update the transaction companion guides. These guides are distributed to submitters as needed.

As Aetna's gateway EDI vendor, Emdeon provides network connection via the HIPAA-standard ASC X12N 5010 formats, supporting claims and encounter submission (837) and real-time transactions (270/271, 276, and 278). Emdeon also supports alternative technology platforms and format options (for example, 4010) for clients not able to submit data in the most current 5010 format. In addition, ICD-10 and ICD-9 coding will be received and submitted by Emdeon following the ICD-10 required regulatory compliance date currently expected to be September 1, 2015.

Emdeon delivers HIPAA-compliant transactions and responses and is CAQH/CORE-certified, Phase I, II, and III compliant. Emdeon is also Electronic Healthcare Network Accreditation Commission-certified and works with an independent auditor annually for accounting standards, SSAE16/SOC1 Level II.

HIPAA security regulations

We have maintained compliance with HIPAA security regulations since the day they became effective on April 21, 2005.

We immediately adopted security standards to protect the integrity and confidentiality of electronic records and transmissions. As part of implementing these standards, we completed a policy and procedures gap analysis, which included revisions to our policies and procedures and new policy development. We completed a detailed access controls review of major systems, and we implemented a risk management process along with a secure messaging system to encrypt e-mail traffic for protected health information (PHI) or other confidential information across the Internet.

Administrative, physical, and technical safeguards

We have administrative, physical, and technical safeguards in place to implement Title 45, Part 164 of the Code of Federal Regulations. With respect to administrative safeguards, we closely oversee our security management process, which includes:

- Workforce security
- Workforce clearance and termination procedures
- Information access management

Through our annual HIPAA risk assessment, we evaluate the potential risks and vulnerabilities to the confidentiality, integrity, and availability of the electronic PHI we hold, with our business unit privacy and security leaders working closely on all assessments and audits.

Physical safeguards

With respect to the physical safeguards mandated by 45 CFR § 164.310, we maintain contingency operations and a facility security plan, requiring access control and validation for all staff and upholding strong workstation use policies and security procedures. Other physical safeguards include:

- Prominently placed HIPAA bins in all departments to make certain the proper disposal of PHI
- Locked cabinets in which PHI is housed
- Use of a fully secured building in which we work:
  - A security guard on site 24/7
  - Assigned security badges to each member of our staff by role with access limited to an as-needed basis
  - A requirement that visitors must sign in and provide identification; visitors are issued temporary passes and must have an escort to travel within the building.

Technical safeguards

We adhere to the HIPAA technical safeguard requirements (defined in 45 CFR § 164.312), employing unique identification procedures and setting all computer terminals to automatically log off after a predetermined period. We guard against unauthorized access of electronic PHI with a stringent transmission security policy to protect against data being transmitted over an electronic communications network. These safeguards include:

- Staff are prompted and required to change their passwords every 90 days.
- Data files containing PHI transmitted between covered entities are encrypted through secure channels; these files include HIPAA-compliant claim files containing PHI from a clearinghouse and 834 files from Iowa Medicaid Enterprise.

Protecting the privacy and security of sensitive information is one of our highest priorities. Accordingly, we encrypt all e-mails that contain member-specific health and financial information. Some examples of this information include personal and demographic information such as name, Social Security number, and address; employment information; information about payment of benefits; provider information; diagnostic or treatment information; claims status information; and information related to mental health or sexually transmitted disease services.

HITECH-specific compliance activities

We implemented compliance with the HITECH act and will continue to remain in compliance as new regulations are issued. We have updated our policies, procedures, and compliance activities to meet the process for defining and reporting data breaches as modified by the HIPAA Omnibus Rule effective March 26, 2013.

Our policies, procedures, and privacy and confidentiality safeguards meet all HITECH provisions to include requirements addressing:

- Data and security breach notification
- Business associate agreements
- Accounting for disclosures, including those disclosures that fall under Treatment, Payment, and Health Care Operations

Attachment 5 – Section 13.1, Question 7

Describe your proposed electronic case management system and all information which is tracked in such system.

Our member assessment process is supported by our web-based care management business application, which incorporates many of the necessary assessment protocols and requirements in electronic format. The application enables our Case Managers and other staff (who have a business need) to review a member's assessment and other key administrative and historical clinical data, such as enrollment history, contact information, diagnosed conditions, prior authorizations, medication history, laboratory results when available, discharge planning notes, and claims history.

With member agreement, Care Plans are available to providers through our care management system. Our experience has taught us that Care Plans often strengthens the relationship between the member, the member's family or caregiver, and the member's PCP, Patient-Centered Medical Home (PCMH), or health home.

When completed, the member indicates their agreement with the plan by signing the document. The member and the member's family or caregiver have access to their Care Plan through our care management business application. This application is secure and user friendly. The member's PCP/PCMH/Health Home also has web-based access to the member's Care Plan and is notified through our web portal of any changes in the plan. It is our experience that this access is an important factor in the member using the Care Plan when visiting their PCP/PCMH and when making important health care choices.

Our member-centered care management program holistically integrates the assessment and care coordination for member needs related to physical and behavioral health (including chronic conditions), psychosocial variables, and LTSS needs. It maintains documentation of care and service plans, gaps in care, and tracking of specialized programs to appropriately coordinate care across an episode or continuum of care.

Tracking care management data

A sophisticated set of technologies form the structure of our care management program. We apply enhanced technology for early identification of members eligible for care management, while our predictive modeling and assessment tools help us place members in the right level of care management.

We use several integrated systems to track and apply care management data:

- **Care management application** – Service coordination activities, assessments, and Care Plans
- **QNXT™ –** Utilization data, including authorizations and paid claims
- **Internal auto authorization applications and CareWebQI –** Prior authorization and clinical review data
- **The Inpatient Census (IP) Tool –** Members currently receiving inpatient care, including readmission risk scores, assigned Case Managers, and discharge planning data. The tool features a direct link to the member profile, which includes a 12-month overview of claims and authorization data in a click and allows the user to navigate through the different levels of detail. Additional report features provide operational support for monitoring staff assignment, member length of stay, and facility information.

Attachment 5 – Section 13.1, Question 8

Indicate if an Electronic Visit Verification (EVV) System is proposed and what methodologies will be utilized to monitor member receipt and utilization of HCBS.

Electronic visit verification (EVV) system and monitoring

We propose our integrated, multi-dimensional approach to monitoring provision of authorized home and community-based services (HCBS). We will capture monitoring data on the amount, frequency, duration, and scope of each service in accordance with the member's service schedule documented in the Care Plan. Early notification of any concerns or issues with service provision helps us immediately identify and address any gaps in care. We propose to implement an EVV system in Iowa that is consistent with tools currently used by LTSS providers and that minimize provider burden.

Our monitoring methods include member-focused verification, claims analysis, and auditing:

- QNXT™ captures scope and duration of services.
- Our Care Management Information System identifies gaps in preventive and other scheduled care and services.
- We contact the member to verify start of services within five days of the planned service start date and at least monthly thereafter for monthly service updates.
- We use member and representative satisfaction surveys to assess views of care management services.
- We collaboratively monitor any gaps in services to make certain we can implement backup and contingency plans when appropriate.
- We track member grievances, complaints, and CAHPS® as quality indicators to identify trends associated with service delivery and improvement opportunities.
- We capture reporting on member authorizations and how those authorizations match the services actually provided.
- We will implement EVV in Iowa to identify service gaps immediately.

An analysis of claims payment will help us verify that services were provided. To address the time lag between the authorization and provision of services and the payment of claims, we will audit claims data monthly and compare the data with open authorizations to address under-utilization issues. Our claims review processes determine if the member was hospitalized, admitted to a rehabilitation or detoxification facility, or was out of state.

Systemic service gaps may be an early indication that a provider is experiencing capacity issues or staffing challenges and this indication would allow the Provider Services team to be proactive and work with the provider to develop interventions to correct any impact to members. Interventions may include working with providers to increase staff expertise or to find ways to add capacity. We may, in certain instances, take action against providers if we find they cannot deliver the services for which they are contracted. If we identify that we need additional providers to meet member needs, we may add additional providers to the network or work with existing providers to develop additional capacity.

We expect EVV to helps improve the quality of care by helping us validate that the authorized services were actually provided on site, on time, and by the authorized provider. As a result, we can immediately identify any gaps in care and quickly address them either through the back-up plan or as determined by the member. We currently review EVV reports associated with services reimbursement data. Features of the EVV system include:

- Ability to schedule and modify worker hours and services
- Start time window that allows call-in within 5 to 15 minutes of scheduled time
- End time window that allows call-out within 5 to 15 minutes of scheduled time
- Real-time notices of delayed service visits and missed visits
- Use of participant telephone number (provide justification if other than the telephone of a paid staff worker)
- Use of a toll-free telephone number for calling in
- Bill generation using data recorded from the telephone system
- Security and HIPAA compliance
- Capacity for alternate time verification arrangements when services are rendered outside the home
- Capacity for biometric identification of the person providing the services

Attachment 5 – Section 13.1, Question 9

Describe in detail how clinical records, as described in Section 13.1.13 will be maintained in your information system.

We store Aetna Medicaid data in relational databases using Microsoft SQL Server 2008 R2 architecture. Table 13-2 identifies the designated systems that store each element of clinical data.

Table 13-2: Locations of clinical data

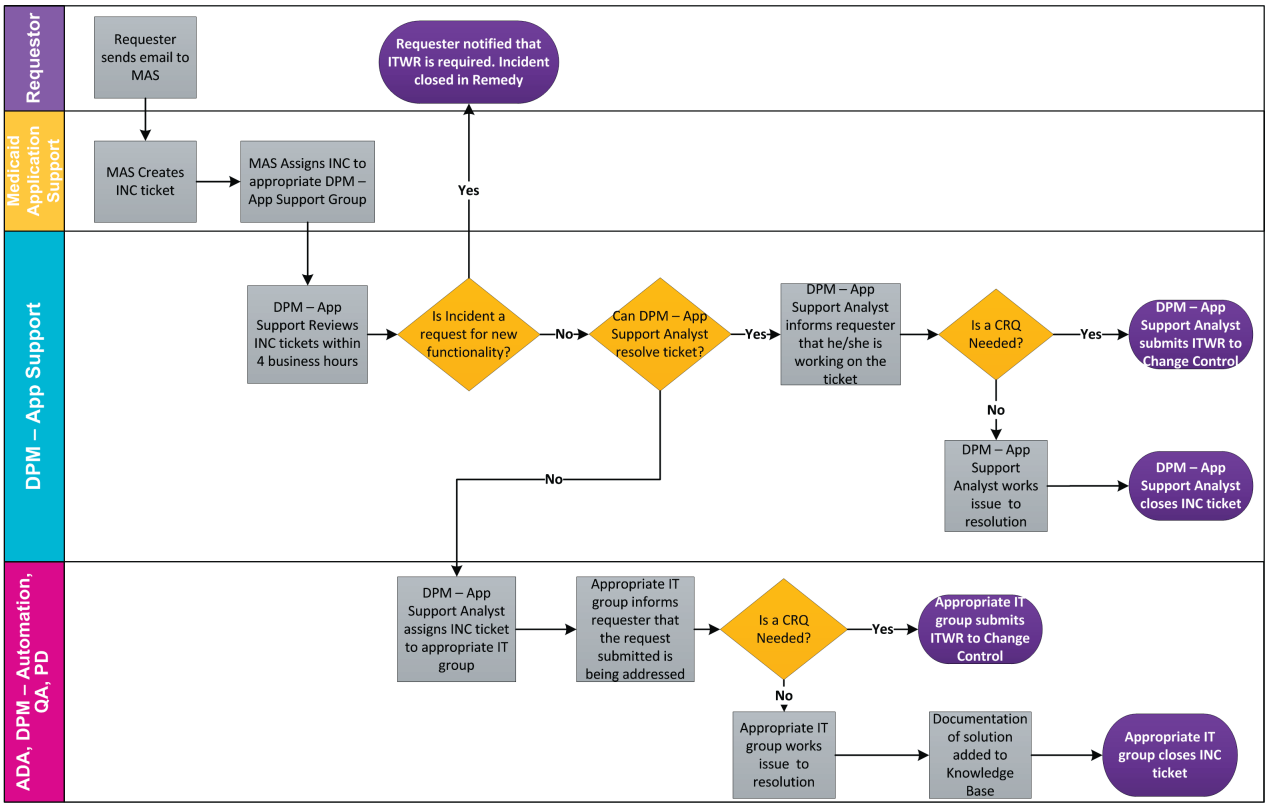
Clinical record data	IT system location
Diagnosis	Care Management system
Level of functioning	QNXT™ or Care Management system
Services authorized	PROPat \ CareWeb QI
Services denied	PROPat \ CareWeb QI
Missed appointments	Care Management system
Emergency Department	QNXT™
Treatment planning	Care Management system
Medication management	Care Management system
Inpatient data	QNXT™ or Care Management system
Joint Treatment planning	QNXT™ or Care Management system
Discharge planning	QNXT™ or Care Management system

Attachment 5 – Section 13.1, Question 10

Submit system problem resolution plans and escalation procedures.

Our Medicaid Application Support (MAS) group manages change-related incidents and ongoing production control incidents. We will submit our system resolution plans and escalation procedures for Agency approval and implement and adhere to Agency-approved plans. We will also notify and work with the Agency immediately upon identification of network hardware or software failures and sub-standard performance, conduct triage with the Agency to determine severity level or deficiencies or defects, and determine timelines for fixes. Figure 13-8 outlines our issue resolution procedures.

Figure 13-8: Issue resolution workflow



The MAS group creates an incident ticket (Figure 13-9) with the request and assigns it to the appropriate support group by category and priority. We classify priorities as critical, high, medium, or low, while we classify impact based on business criticality and regulatory or compliance needs. Impact types include:

- Extensive or wide-spread
- Significant or large
- Moderate or limited
- Minor or localized

The Support Group Lead analyzes the issue and assigns it to a group member for resolution. System defect correction begins with creating an incident, followed by the change order process. The support staff resolves the issue based on the service level agreement requirements of the ticket, which in turn depends on the urgency of the ticket. When we identify a critical issue, we create an Immediate Response Team to resolve the issues on an accelerated timeline. Please see Appendix P for a sample incident ticket.

Attachment 5 – Section 13.1, Question 11

Submit sample release management plans.

Sample release management plans

In Appendix P, we include a sample release management plan. It identifies sample development benchmarks and timelines for each stage, including development timelines, quality assurance testing, user acceptability testing, and deployment dates.

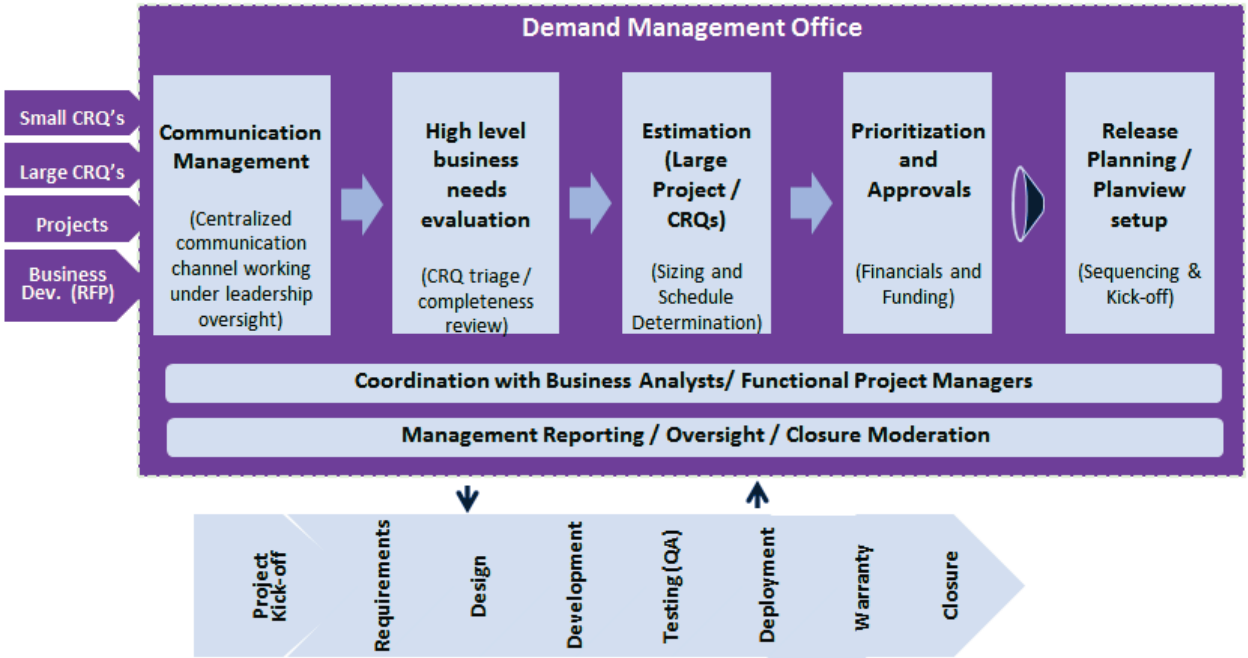
Our change and release management process provides a structured, fully recoverable framework in which to implement and manage releases of system changes in accordance, and on schedule, with federal, state, and Contract-specific requirements. Our implementation schedule for the Agency will provide full conformity with federal and Agency-specific standards. Small projects and enhancements have ad hoc releases, while large project releases are driven by regulatory mandates or business needs.

Change management and change control process

Requests for large-scale enhancements and maintenance activities require approval through Aetna's IT demand management process before the project begins. The demand management process ensures that all projects within IT have the proper level of governance and visibility. We evaluate projects based on priority, size, and how they support our goals and objectives. These goals include growing business, providing best-in-class care management, and providing technology solutions to our members and providers.

Figure 13-9 summarizes the demand management function.

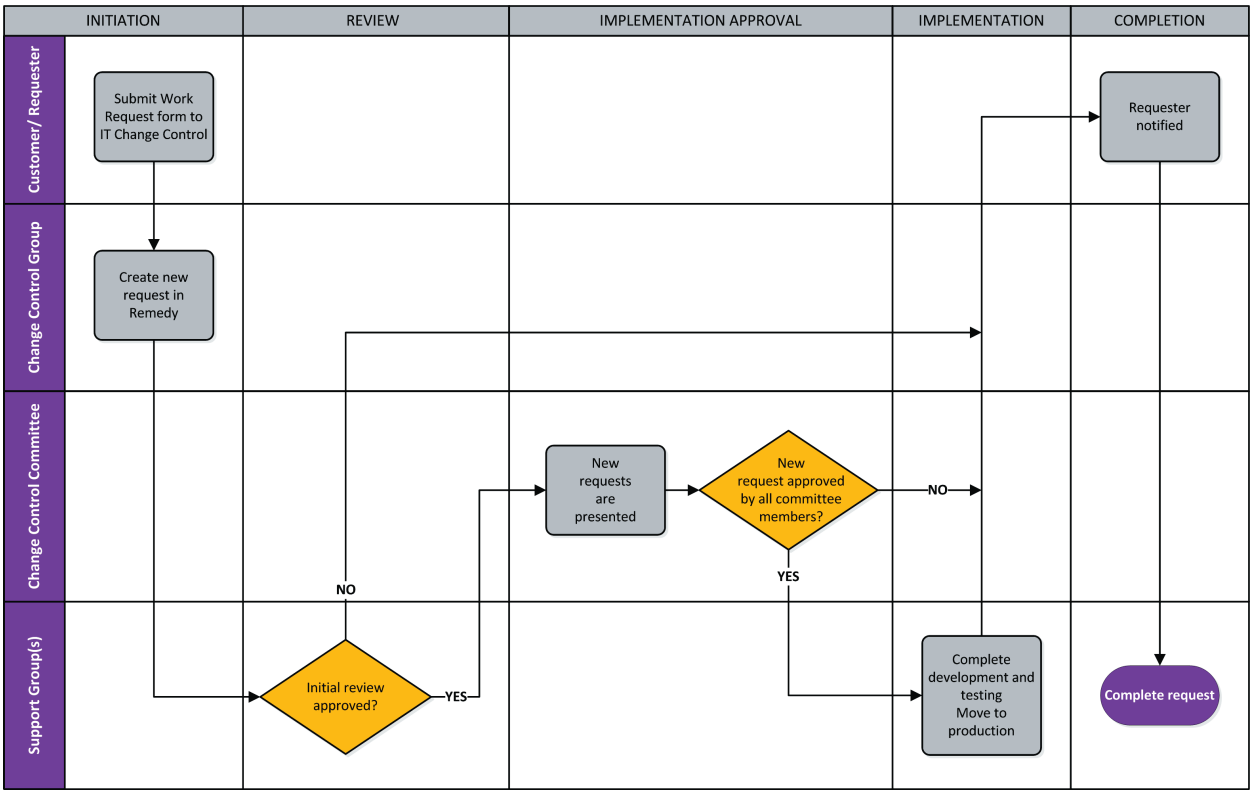
Figure 13-9: Centralized Demand Management Office



IT is engaged early in the process, allowing optimal opportunity for feedback in support of business decisions. Approved projects are subject to the change management and change control process (described below), detailed planning, and resource forecasting and scheduling to fulfill the Contract obligations and Contract commencement dates.

We welcome Agency participation in the review and approval of change orders. Moving forward, we encourage active review and formal approval of change requests, requirements, testing results, and other system development life-cycle activities as appropriate. Aetna Better Health will provide the Agency with monthly change order updates, including the status of active and planned changes. Figure 13-10 summarizes the change control process.

Figure 13-10: IT change control process diagram



Most changes to systems originate as an IT Work Request (ITWR). Authorized Aetna Better Health personnel create the ITWR. We manage requests in our change and incident management application. Our change control committee must approve requests before work begins. Likewise, the Agency has the authority to approve or reject change requests.

Change requests may be submitted for a variety of reasons including:

- Implementations—primary systems, ancillary systems, and file exchanges set up to provide managed care services to the Iowa's population
- Changes to enhance user effectiveness, operating efficiency, or cost-effectiveness
- Regulatory change affecting systems
- Internal or external mandates (Aetna Better Health, Aetna Medicaid, State, and federal)
- Proactive effort to impact system scalability or efficiency

We assign system or application changes (for enhancements and large projects) to a project team through a change request. Throughout the software development cycle, we track change requests via a workflow management tool. Defect fixes follow the incident management process. However, defects that require changes in code go through the software development life cycle of a maintenance change order.

For large system changes, the Aetna Medicaid PMO team is the overall change manager, in collaboration with Aetna Better Health leadership. We assign Project Managers (PMs) to each change project. The IT Demand Management Office works with IT leadership in assigning the PM. For small projects and enhancements, the change manager and PM are typically the same. We have change processes in place

at the IT cross-functional and functional team level, with multiple subject matter experts representing multiple business and IT domains to identify and track all impacts for any system change.

Representatives from a variety of areas (Aetna Better Health, Aetna Medicaid, IT business analysts, IT architects and developers, and IT Quality Assurance) evaluate the impacted application to identify any effects to downstream applications as early as possible in the process. Each individual team member also has historical documentation to assist them in evaluating system impacts. For example, our IT department has operational process blueprints indicating interdependencies and connections between various IT systems and applications. This blueprint is the guide for building impact assessments and mitigating dependency conflicts. We create architectural blueprints for each application, allowing us to quickly assess system changes and impacts to individual processes. If the team determines a change impacts more than the primary system being changed, we create change requests for each system impacted. These additional change requests are linked back to the main change request. Project team members are accountable for signing off on each change request, main and linked, at various points throughout the lifecycle of any system change.

We manage and execute system changes through the software development lifecycle as described below; there is a formal approval between each phase for logical progression of the project.

REQUIREMENTS PLANNING

Requirements planning involves user interviews, documenting functional and non-functional business requirements, and tracking blocked and conditionally approved requirements. It includes gathering information about the projected user or intended operating outcome, along with identification of any downstream systems or datasets that could be affected by the change.

DESIGN

This next phase involves determining the scope of the targeted change and documenting an item-by-item detailed design, which may include system architecture, coding requirements, data modeling, interface considerations, and any workflows or supporting documentation developers may need to build.

DEVELOPMENT

Development involves constructing system components, including reports and interfaces, as well as configuring the various information systems and the producing documentation—including training materials and user manuals.

TEST (QUALITY ASSURANCE AND USER ACCEPTANCE)

This phase involves testing the system using selected sample datasets and populations to assess the accuracy of delivered changes against known longitudinal data outcomes or test case scenarios. During the Test Phase, we also train all key stakeholders on the change.

We perform regression testing to confirm that the system changes do not disrupt existing functionalities and business operations. User acceptance testing (UAT) follows quality assurance testing to identify any possible issues that may be identified by users most familiar with the results the system should be producing.

We also perform vendor testing for file exchange changes. We share test files with other vendor stakeholders, as appropriate, to validate format and layout validation, as well as verify connectivity.

The project team determines parallel and performance testing needs based on the type of project. For example, if we anticipate a high volume of membership or building a new product, we add performance testing to the project scope.

DEPLOY

Deployment involves activating the configured system, with any changes, for use by its user population. We typically publish change notification through multiple communication vehicles to maximize the user community reach, including e-mail, facsimile, online meeting, and web alerts. In these cases, the Deploy Phase only commences after our business application users, and the Agency, are satisfied with the results of both testing and training. During the Deploy Phase, we update the production environment to include the change. We release updates implemented during this phase so as to not impact the availability of critical system functions. This practice typically means we release during scheduled downtime windows.

POST DEPLOY REVIEW

This final phase involves providing post-implementation support (warranty) to the applications we deployed to the production environment during the Deploy Phase. Business subject matter experts conduct this review and contact the IT team to resolve warranty issues, if any.

SYSTEM MAINTENANCE

Maintenance activities deemed to be comparatively minor, low-risk tasks are routinely performed. An example of such an activity is account administration (for example, user profiles, password resets, user desktop application setup). We mitigate the risk associated with any upgrade by:

- Releasing any upgrade in a secure testing environment to test its impact before promoting it to the production environment
- Maintaining appropriate fallback plans so we can reverse the process and return the system to its pre-upgrade state if necessary
- Training staff and end users on any major system changes resulting from the upgrade

13.2 Contingency and continuity planning

Attachment 5 – Section 13.2, Question 1

Provide a detailed disaster recovery plan and contingency and continuity planning documents.

Maintaining a proactive, effective business continuity or disaster recovery plan

We attach our recovery plan and contingency and continuity planning documents as Appendix Q.

Stability, Competency, and Trust in the Face of Challenge

In 2014, some 59 counties in Iowa received state disaster declarations due to severe storms, tornadoes, high winds, and flooding. The damage to property and infrastructure was extensive, and Iowans are preparing for more extreme weather in the years to come.

Together with Aetna Medicaid, Aetna Better Health has prepared a business continuity and disaster recovery plan for our Iowa operations to address process and strategies:

- To make certain that our members have access to information and services in the event of an emergency
- To expedite business following an emergency

We prepare business continuity and disaster recovery strategies for natural hazards (earthquakes, extreme temperatures, wildfires, floods, storms, pandemics, and tornados); man-made hazards (bomb threats, civil unrest, infrastructure failures, explosions, fires, hazardous materials, criminal acts, and workplace violence); proximity hazards (airports, highways, railroads, flood plains, and nuclear sites); and technology issues (application outage, network disruption, telephone disruption, hardware failure, and utility disruption).

With Aetna Medicaid's support, we will make certain that our plan protects the availability, integrity, and security of data during unexpected failures or disasters.

Aetna Better Health has made careful choices to anticipate and address the Agency's needs by making sure we can continue essential application or system functions during or immediately after failures, disasters, or emergencies:

- **Architecture –** Mirrored information systems and triple-redundant telecommunications
- **Business continuity strategy –** Clear policies, procedures, and mitigations to maintain business processes in a variety of disaster scenarios
- **Disaster backup and recovery –** Requirements and protocols for establishing and maintaining the system operations hierarchy
- **Incident management strategy –** Impact assessment and risk analysis of an incident site, along with procedures and protocols for accountability, organization, staffing, and training
- **Member emergency management strategy –** Year-round proactive education and planning for helping members access care in an emergency

Information and telecommunications systems architecture

Aetna Medicaid's key production and telecommunication systems include the following Aetna Better Health owned and outsourced systems and applications:

- Aetna Medicaid houses key information systems in mirrored data centers in Windsor, Connecticut and Middleton, Connecticut.
- Aetna Medicaid uses triple redundancy for telecommunication services:
  - AT&T hosts Aetna Medicaid's cloud-based services.
  - Aetna Medicaid will augment onsite Avaya call management servers in all Iowa locations with servers in Windsor and Middleton.
- Aetna Medicaid will also provide technical support services.

Business continuity – disaster recovery process

When planning our business continuity and disaster recovery strategies, we have applied the experience gained over 30 years by Aetna Medicaid plans and studied how others have responded to varied types and levels of crisis to develop the best plan. Emergency and disaster situations clarify why we do business—Aetna is committed to being a beneficial piece of the public health system. Our ability to maintain systems and to connect to people in need contributes to the public good in Iowa and across all the states we serve.

Our plan will:

- Specify the onsite dedicated business continuity resource accountable for the success of the plan
- Specify the staff responsible for oversight and administration

- Specify the applicable situations and emergencies and the extent to which strategies vary for each
- Identify the resources needed, based on the type and duration of event
- Indicate the order in which we notify essential parties of the situation and emergency and the timeframes for those notifications
- Describe how members and providers will be notified and how they will access information and services
- Describe the process for updating the plan and timeframes

Our plan will also address ways to mitigate damage, communicate with the Agency and local government, integrate with non-governmental organizations (for example, the American Red Cross and member advocacy groups), and respond to the crisis in a manner that best serves public health.

For example, a plan that Aetna manages in Arizona is a leader with the Heat Relief Network in Maricopa County, an initiative to stop extreme heat-related deaths and illness in Arizona when triple-digit high temperatures pose a particular danger to the homeless and underserved. When heat hits the extreme index, providers and community organizations go into the community and find as many people as they can to distribute water, loose clothing, hats, maps to hydration stations and heat refuge locations, and information on support networks. The program benefits everyone, not just Aetna members.

Our strategies for business continuity and disaster recovery in Iowa include:

- Business continuity
- Incident management
- Disaster recovery
- Member emergency response

Below, we provide a high-level description for all four strategies.

Business continuity

Aetna Medicaid maintains and implements a detailed business continuity program with over 75 plans that address its mission-critical business workgroup operations. These plans include multiple planning scenarios, such as total loss of a building, system failures, a widespread staffing shortage, loss of telework connectivity, and a loss of critical third-party services. For each scenario, Aetna Better Health outlines response strategies and procedures for both short- and long-term business disruptions. The Aetna Better Health business continuity strategy for Iowa will accomplish the following:

- Provide leadership and direction so that Aetna Better Health can appropriately manage business disruptions or potential business disruptions including a pandemic outbreak
- Assess and identify the risks and affects to critical business processes
- Establish procedures to promptly recover required electronic and hard copy data
- Create the infrastructure and actions required to enable critical business processes to continue with minimal impact to Aetna Better Health's customers
- Restore normal business operations once the disruptive event has been resolved

Incident management

Aetna Better Health's Incident Management Plan will quickly implement protective actions to help the occupants of the affected buildings and initiate further activities such as damage mitigation, salvage, communications, and decision-making. The Incident Management Plan invokes appropriate elements of

business continuity plans as required. It directs the affected site and home office response and also coordinates with all other plans.

Disaster recovery

Aetna Better Health's high-level Disaster Backup and Recovery (DBAR) plan will recover a data center and its critical components. The plan derives from over 50 detailed IT infrastructure plans maintained by each critical support area. The plans contain processes and procedures to recover all functions, services, and equipment needed to recover either data center. These plans are centrally maintained by Aetna's Disaster Recovery Planning Services (DRPS) group, are stored at each data center and offsite, and are updated semi-annually or as needed by the respective infrastructure area.

- The DBAR plans document technical and management contacts, application recovery specifics, application dependencies, integrated system synchronization, and checkout procedures. The plans are maintained routinely and use automated recovery processes to verify appropriate data resilience. Application owners and business users, using integrated tabletop simulations, validate these DBAR plans annually.
- Escalation and notification procedures within disaster recovery plans will help verify and notify recovery team members, affected partners, and business unit owners. Aetna Medicaid's role during a disaster is to lead, manage, and staff the various recovery teams, which will also be augmented by additional subcontractor specialists under contract for certain supplemental recovery technologies, which Aetna Medicaid will coordinate.

Member emergency response

Aetna Better Health will build a member emergency response plan that will include:

- Member materials to educate members on how to access their medical records if their provider's office is closed or destroyed, and how and where to obtain services or contact the Nurse Advice Line in case of an emergency
- Call Center scripts to activate before, during, and after an emergency event
- A year-long program of member communication—information specific to creating and maintaining a personal or family emergency response plan
- A process for notifying members of alternate providers if their current provider is unavailable
- A process for handling member complaints and inquiries

Testing of our business continuity and disaster recovery plan

Aetna Medicaid will test our business continuity and disaster recovery plan, no less than annually and at all levels. Our comprehensive testing strategy includes:

- **As part of change management** – Testing after system changes such as new product implementation and unit, system, integration, user acceptance testing, regression testing, and performance or load testing.
- **Testing for incident management plans and for business continuity** – Onsite simulations with all staff, onsite tabletop reviews of multiple scenarios with key staff, building evacuation simulations and fire drills, and DBAR exercises.
- **Testing for software applications** – For change management, testing is part of the software development lifecycle throughout the course implementation. Aetna Medicaid also completes testing on a need basis during ongoing operations and production support after system implementation is complete.

Aetna Better Health's onsite business continuity resources will deliver exercises, conduct testing, and see that maintenance is completed in accordance with the contractual requirements. Each mission-critical business process will conduct an annual tabletop exercise or simulation to validate plan content and strategies. We will update the team contacts in each plan quarterly. The plan reviews confirm that all major plan components remain current. We test the plans during simulation exercises, which we conduct on an ongoing basis with at least three of the simulations done in field offices each year. The plans are also tested during actual events.

We regularly perform testing across a variety of applications and infrastructure components to verify ongoing disaster recovery readiness. Aetna routinely tests recovery elements of technology components, critical processes, and access points.

Monitoring tools and resources

Aetna Medicaid's DRPS uses a server-mapping tool to track both internal and external DBAR server utilization requirements. DRPS also has tools at its disposal to determine technology and architecture requirements.

We will update our business continuity plans and procedures to meet emerging needs. Annual testing of business continuity and incident management plans, employing simulated disasters and lower-level failures, provides an opportunity for local business process owners and Aetna Better Health site leadership to demonstrate and validate system recovery capabilities for the Agency.

13.3 Data exchange

Attachment 5 – Section 13.3, Question 1

Describe your process for verifying member eligibility data and reconciling capitation payments for each eligible member.

Member eligibility data

Aetna Better Health accepts and processes the standard X12 Benefit Enrollment and Maintenance (834), Version 5010 enrollment file provided by the Agency as the mechanism to update member enrollment and disenrollment information. This HIPAA file format also supports Agency-required elements. QNXT™ uses the membership data contained in these data files to verify eligibility requests, authorize services, and process claim transactions.

Aetna Better Health meets the Agency criteria for the timely loading of member data. The Enrollment Services team resolves daily 834 change files in one business day and reconciliation files within five business days. We reconcile member eligibility information between the 834 file and the membership files in the QNXT™ system. The Enrollment Services team will identify, research, and validate exceptions, making the appropriate updates in QNXT™ and notifying the Agency as required.

After the system imports and accepts the data in the 834 file, the data is available for use by the QNXT™ system for further member eligibility verification such as claim adjudication. The enrollment data is sent to subcontractors such as dental or vision providers for use in their systems.

Reconciling capitation payments

We use both daily and weekly HIPAA-compliant Benefit Enrollment and Maintenance (834) transaction data and twice-monthly HIPAA-compliant Premium Payment (820) transaction data to process and reconcile payment data. We follow standard, documented, and Agency-approved processes and procedures for receiving and processing premium payments.

If we discover a discrepancy in eligibility or capitation, we will notify the Agency within 30 calendar days of discovering the discrepancy and no more than 90 calendar days after the Agency delivers the eligibility records. We must return any capitation or overpayments to the Agency within 45 calendar days of discovering the discrepancy via procedures determined by the State.

ACCURATE MEMBER FILES ARE KEY TO SUCCESSFUL RECONCILIATION

The Agency determines managed care membership eligibility and health plan assignment. They send us and enrollment file with member assignments, demographic, and other eligibility data via the 834 transaction that we load to our system. We process 834 files within hours of receipt and monitor accuracy daily to keep our eligibility data in sync with Agency data. Current, accurate member data is critical to timely, accurate premium payment processing, as well as accurate, appropriate eligibility verification and claims processing.

The Information Systems Department receives and downloads daily 834 transactions each weekday and a reconciliation ("Recon") file on Saturdays. The daily files contain any member changes, including member additions and terminations, as well as demographic changes for current members. IT processes the file and notifies the Enrollment Department when it is complete.

After we upload the file, the system produces an edit report featuring a list of "fatal errors" (member records not automatically loaded from the daily 834 file into our system). Each day, the Enrollment Department manually enters these member records into the system.

We process Saturday reconciliation files the same as we do the daily 834 files. On Monday (or the first business day of week), Enrollment uploads the Recon file into system. The system generates an edit report containing additions (members on the State file but not in the system) and terminations (members in the system but not on the State file). For terminations we run the Recon file through a batch process to terminate these members. We run a separate process for additions to load just these members.

PROCESSING CAPITATION PAYMENT FILES PROMPTLY

The State will pay us premiums based on contracted rates per region and daily prorating. Approximately every other week, they will send us an 820 file, which contains all payment details for the forthcoming wire transfer, as well as the monthly totals for membership with the corresponding premiums. Aetna Medicaid will have the staff, systems, and documentation in place to promptly and accurately process premium payment files.

When we receive an 820 file, IT translates and processes the file and creates a text file report for both premium payments and delivery and neonatal intensive care unit payments. Each report contains detail required for posting the payments and recording premium and member months. This processing takes less than 24 hours.

Policies and procedures for reconciling capitation payments

Finance reviews premium files for reasonableness based on membership and premiums for prior months, as well as on weekly enrollment reports provided by the Agency that indicate gains or losses from the prior month. Other factors that may affect membership and premium levels are the auto-assignment level in each region or competitors entering or exiting the market. The prorated membership will always be somewhat lower than the weekly enrollment report, which gives a count of current membership rather than a prorated number. Retroactive member changes are generally low, except for the few times a year that the Agency performs retroactive reconciliations. If there are unexpected and higher-than-usual retroactive member eligibility trends, we may contact the Agency's

finance team to inquire about any discrepancy. This conversation helps us understand the reason for the retroactivity and helps the Accounting Department validate that our reports are running correctly.

Monthly validation

We have a systematic process to reconcile the premiums that we receive to our enrollment files. We calculate premiums in the data warehouse based on membership and rates loaded into the warehouse. We compare this rate by member to the Agency's electronic remittance advice (ERA), which is loaded into the data warehouse each month. The data warehouse generates an exceptions report indicating members for whom we have not received the expected payment. The Accounting Department reviews exception reports quarterly and resolves identified issues or discrepancies.

During the first week of the new month, the Agency sends a wire transfer to us for the amount of the premium per the ERA. The amount of the wire transfer should tie exactly to the amount recorded as premium revenue based on the above procedures. This process confirms that all data has been properly transmitted and that our system queries are working appropriately. Should the amounts not be equal, we research the discrepancy.

As part of the month-end financial review process, the Accounting Supervisor, Manager, or Controller reviews the ERA and verifies that the balances in both the premium revenue and premium receivable accounts, as shown on the income statement and balance sheet, equal the total revenue per the remittance advice.

Bank reconciliations

We prepare bank reconciliations each month for each cash account on the general ledger and our bank account. Accounting staff prepare the bank reconciliation and a Manager, Director, the Controller, or the Chief Financial Officer review the documentation for completeness, accuracy, and any items that may need to be reconciled. Finance works with the appropriate areas to complete a prompt reconciliation.

13.4 Claims processing

Attachment 5 – Section 13.4, Question 1

Describe your capability to process and pay provider claims as described in the RFP in compliance with State and Federal regulations.

Claims editing and payment improvement

Our claims adjudication system is a HIPAA-compliant, rules-based information processing system. It includes 28 integrated modules that maintain and process health care administration data, allowing us to increase administrative efficiency, improve the quality of care, and position ourselves for compliance with the International Classification of Disease, 10th Edition.

The system contains every data element required for claims data submission. The provider module contains the unique provider identification number generated by the system, plus all billing and tax reporting information. The claims module shows the date of receipt, the history of actions taken on each claim, and the date of payment, including the check number. The system accumulates claims by specific benefit limits and lifetime benefit rules. It scrubs and edits this data for accuracy during claims processing and payment.

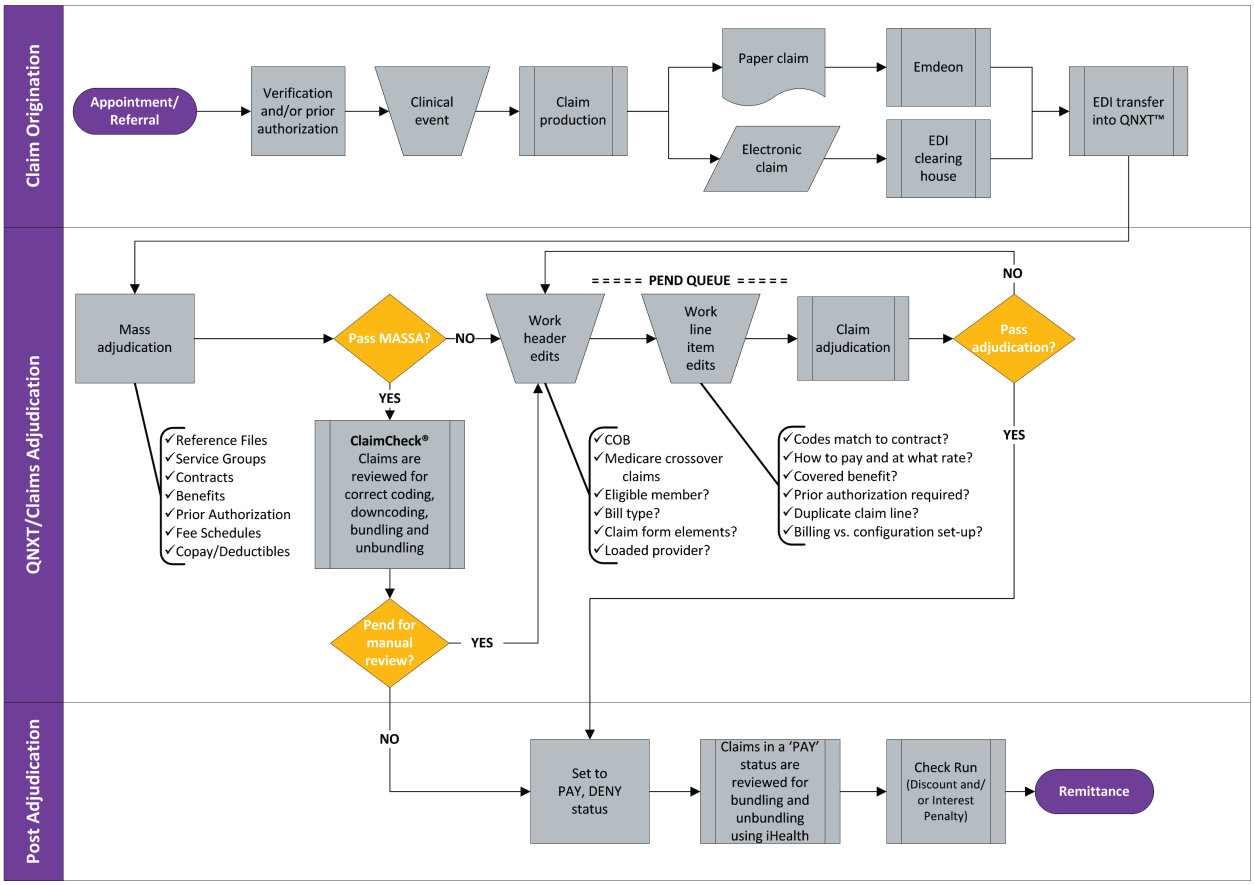
Our process allows us to meet clean claims goals, handle providers both in and outside of our network, accept paper and EDI claims with an NPI number, provide a daily file of shadowed claims, measure electronic and paper claims (and encourage providers to use electronic), and collaborate with other plans to improve the overall claims process while reducing administrative burdens for providers.

Figure 13-11 illustrates the claims adjudication process and how TPL and coordination of benefits (COB) validation interacts within the claims adjudication process. There are three basic phases in the claim lifecycle: claim origination, claim adjudication, and post adjudication. In the claim origination phase, the provider obtains any service verification and prepares either a paper or electronic claim. The claim is submitted to a claim clearinghouse such as Emdeon for routing to us as the health plan for processing.

We load the claims into our claim processing system for further processing. At this point, the claim enters the claim adjudication phase. The system applies a series of edits, as described below, during this process. The claims will pay, pend, or deny in the adjudication process.

If the claim passes all edits, the provider is paid for the services rendered. If the claim fails edits and has a status of pend, further action is taken. A pend claim requires an analyst to review the claim. A denied claim may or may not require further action on behalf of the provider, depending on the reason for the denial. All adjudication reasons are noted on the provider's electronic remittance advice for reconciliation purposes using standard reason codes.

Figure 13-11: Life of a claim



Claims processing, edits, corrections, and adjustments

Edits applied during claims processing and payment include the following:

- **Member eligibility –** Validates the date of service against the member's enrollment information to determine whether the member was eligible on the date of service. If the member was not eligible, the system will automatically deny the claim using the appropriate HIPAA-approved remittance comment.
- **Covered or non-covered services –** Determines coverage of specific services using CPT, revenue codes, or the Healthcare Common Procedure Coding System (HCPCS) under the Contract or benefit rules.
- **Required documentation –** Validates certain services that require additional documentation before the claim can be adjudicated.
- **Services within the scope of the network provider's practice –** Verifies by provider specialty to allow certain procedures to be performed only by selected provider types.
- **Duplication of services –** Identifies duplication of services submitted.
- **Prior authorization –** verifies for prior authorization of specific services.
- **Invalid procedure codes –** Validates code sets. As new codes are added, terminated, or changed, the codes are updated in the system to always stay in compliance with HIPAA standards.
- **COB/TPL –** Identifies and manages COB and TPL.
- **Correct Coding Initiative (CCI)** – validates for CCI-compliancy.

QNXT™ has system edits in place to validate situations in which members have other commercial health, casualty, workers compensation, or Medicare insurance coverage. If we discover that a member has other insurance coverage, we will document the coverage in QNXT™.

If we receive claims with an EOB attached for covered members with documented other insurance coverage, we will process these claims with Aetna Better Health as the payer of last resort. The system will produce a Health Care Claim Payment or Advice 835 transaction for response to the provider.

Attachment 5 – Section 13.4, Question 2

Describe your plan to monitor claims adjudication accuracy.

We apply industry standard metrics of 99% accuracy for financial and 98% for payment accuracy. We understand we must adjudicate 100% of claims of all clean provider-initiated adjustment requests within 10 business days of receipt. We also understand we must reprocess all claims processed in error within 10 business days of the error or upon a schedule approved by the Agency.

Our claims system and processing procedures using a variety of techniques to monitor the accuracy of claims adjudication. These include:

- Duplicate billing logic
- ClaimCheck® edits
- Coding accuracy
- Durable medical equipment editing
- Procedure code guidelines
- Procedure code definition policies
- Technologies to detect questionable billing practices

Duplicate billing logic

The claims adjudication system edits the data input to determine duplication of services. Examples of such duplication include same member, same date, same network provider, same service, or any combination of these criteria. Claims lines set to a status of "Pay" are subjected to duplicate logic. This

logic protects against paying for services rendered by the same provider or other providers within the same provider group.

ClaimCheck® edits

ClaimCheck® is a comprehensive code auditing solution that supports the claims adjudication application by applying expert industry edits from a provider-recognized knowledge base to analyze claims for accuracy and consistency with our policies and procedures. ClaimCheck® clinical editing software identifies coding errors in the following categories:

- Procedure unbundling
- Mutually exclusive procedures
- Incidental procedures
- Medical visits, same date of service
- Bilateral and duplicate procedures
- Pre- and post-operative care
- Assistant surgeon
- Modifier auditing
- Medically unlikely

The system also performs edits related to select durable medical equipment (DME) payment policies that align with services covered by long-term care policies. These DME edits include DME rentals, oxygen and oxygen systems, hospital beds and accessories, external infusion pumps, and anatomic or functional modifiers required for DME services.

Coding accuracy

If the services are up-coded or unbundled, ClaimCheck® will alert the Claims Department to deny the claims line and provide the specific clinical editing policy to justify the denial. The claims line will deny, providing the appropriate HIPAA remittance remark on the EOB.

Procedure code guidelines

System edits are in place to follow the guidelines and instructions in the American Medical Association (AMA) CPT-4 Book and the CMS HCPCS Book on code usage. For example, if a vaccine administration code is billed without the correct vaccine or toxoid codes, Aetna Better Health will deny the code as inappropriate coding based on industry standards. According to the AMA CPT Book, the provider must report the vaccine and toxoid code or codes as well as the vaccine administrative code.

Procedure code definition policies

The system supports correct coding based on the definition or nature of a procedure code or combination of procedure codes. These editing policies will either bundle or re-code procedures based on the appropriateness of the code selection. For example, if a provider attempts to unbundle procedures, the system applies editing logic that will bundle all of the procedures billed into the most appropriate code (if a provider bills an office visit and also bills separately for heart monitoring with a stethoscope during the same visit, the system rebundles the service into the appropriate evaluation and management or office code).

Technologies to detect questionable billing practices

Additional system capabilities enable consistent and accurate administration of claims adjudication policies. Professional claims that reach an adjudicated status of "Pay" are automatically reviewed against nationally recognized standards such as the CCI and recommendations applied during an automatic re-adjudication process. This system editing capability uses historical claims information to

detect and correct questionable billing practices. It identifies potentially fraudulent and abusive patterns. Table 13-3 illustrates CCI control edits. These edits include:

Table 13-13: CCI control edits

Type of edit	Edit description	Results
Member eligibility	The adjudication system validates the date of service against the member's enrollment segment to determine whether the member was eligible on the date of service.	If the member was not eligible on the date of service, the system automatically denies the claim using the appropriate HIPAA-approved remittance comment.
Covered or non-covered services	The system automatically determines whether specific services, using the CPT, Revenue, or HCPC codes, are covered under the Contract or benefit rules of the plan.	If services are not covered, the system automatically denies that claims line. If the services are up-coded, or unbundled, the system returns a recommendation to deny the claims line along with the specific reason, offering the appropriate HIPAA remittance remark for the EOB.
Required documentation	For certain services, the system is configured to require additional documentation.	The claim will pend or reject until the documentation is received. For example, a signed consent form is required documentation for sterilization procedures.
Services within the scope of the network provider's practice	The system is configured by specialty to allow certain procedures to be performed only by select network provider types.	The claim will reject if the procedure does not match the provider specialty or taxonomy. For example, the system will not process a claim for a magnetic resonance imaging test by a gastroenterologist.
Prior authorization	The system has a separate configuration for prior authorization templates and associated service groups. This configuration provides the flexibility to create code-level authorizations, if needed. The system is organized to automatically identify certain types of authorizations for Medical Director review. Claims edit rules validate the claim against the network provider, member, dates of service, services rendered, and units authorized.	The claim will pend or reject until the authorization received. For authorization cases requiring Medical Director review, the system will pend the claim until the review is completed and notated in the system.
Invalid procedure codes	We configure reference files by year and procedure code. As new codes are added, terminated, or changed, we update the codes in the system so that the system is always in compliance with HIPAA standards.	If a network provider bills a code that has terminated, the system will deny the claims line and advise the network provider the code is invalid.

These system edits and metric reporting promote the accurate processing of claims, identify needed process improvements, and support effective claims adjudication.

Attachment 5 – Section 13.4, Question 3

Describe your provider claims submission process, including provider communications addressing the provider claims process.

Although we strongly encourage electronic filing of claims, we accept claims submitted in both electronic and paper form from our providers. Providers will work with their electronic billing vendor to

submit EDI claims to us. Multiple clearinghouses offer electronic claim submission, providing a broad range of submission options for our providers. Providers can access our portal 24 hours a day to submit and verify prior authorizations, confirm enrollment, check claim status, review covered health services, and view program benefits.

The Claims Department maintains a toll-free Claims Inquiry Claims Research (CICR) line from 8 a.m. to 5 p.m. Central. CICR Representatives can answer provider telephone inquiries regarding claims status, use call tracking functionality to track inquiries, and provide status or process adjustments to previously processed claims.

Paper claims are submitted to a post office box for imaging and conversion to an electronic claim format. Our current arrangement is with Emdeon for electronic submission. Through Emdeon we can offer a web-based solution for CMS1500 forms.

Claims attachments

We accept claims attachments in a paper format. The attachment must be included with a paper claim submission. Processing timelines do not differ between claims with and claims without attachments. We plan on accepting the electronic ACS X275 version for claims attachments to coordinate with the effective date of the federal requirement.

Attachment 5 – Section 13.4, Question 4

Describe policies and procedures for monitoring and auditing provider claim submissions, including strategies for addressing provider noncompliance; include any internal checks and balances, edits or audits you will conduct to verify and improve the timeliness, accuracy, and completeness of data submitted by providers.

Audit of claims sample

Managed separately from Medicaid Claim Operations, the Medicaid Claim Quality Program independently assesses the effectiveness of our claims system configuration and claims procedures, and the resulting adjudication process.

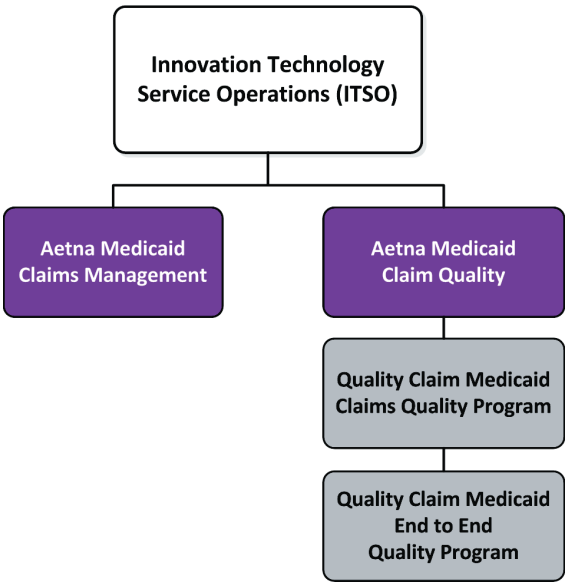
We will complete all audits using the attributes required by the Agency, including:

- Correctly entering claims data into the claims processing system
- Associating the claim to the correct provider
- Obtaining the proper authorization for the service
- Correctly applying member eligibility as of the processing date
- Confirming that the allowed payment amount agrees with contracted rate and the terms of the provider participation agreement
- Confirming that duplicate payment of the same claim has not occurred
- Applying the denial reason
- Considering and applying the co-payment
- Identifying and applying accurate patient liability
- Applying the correct effect of modifier codes
- Considering and applying other insurance, including long-term care insurance
- Applying benefit limits

Quality Auditors report directly to the Business Program Manager of Claims Quality within Innovation Technology Service Operations (ITSO). Quality Auditors do not have claims adjudication access and thus

cannot alter claims data. The Claims Management Department is a separate department within ITSO whose role is to confirm the proper segregation of duties for audit purposes. Figure 13-12 shows the program structure.

Figure 13-12: Claims application structure



Our Medicaid Claims Quality Program and End-to-End Quality Program facilitate the accuracy of claims payment. While both programs play a role in monitoring and improvement, the scope of each is different, as described below.

- **Medicaid Claims Quality Program –** Identifies errors, policies, and processes contributing to inappropriate claims payments from a constituent focus. This program identifies opportunities for quality improvement, trending, and training, so that regardless of the functional area responsible for the root cause of the claims error, errors will be mitigated if the claim is incorrect from a member, plan sponsor, provider, or government entity perspective. This program audits using automated and ad hoc reporting to identify outliers for further review and analytics or recovery and recoupment.
- **End-to-End Quality Program –** Audits adjudicated claims and system configurations to promote accuracy and compliance with established policies, procedures, management service agreements, and contracts. The program does not identify discrepancies within Operations policy and procedures. The scope includes contract, benefit, and provider audits. The system can perform targeted claims audits upon request.

Together, these programs and processes support the policies and procedures for internal monitoring and auditing of the claims adjudication system and will promote the integrity of the adjudication system as a whole by minimizing payment of erroneous claims.

Sampling methodology

Our auditing process will use a statistically valid random sampling method. We determine the standard audit sample sizes by using a statistically valid sample, based on the total population size and claims category as follows:

- **Manual random selection –** A random selection of 2% of adjudicated claims with a billed amount less than $50K. This 2% selection is pulled from the claims analyst's prior day's listing of adjudicated claims.
- **High-dollar claims –** 100% of claims with a billed amount of $50K or greater and claims with a paid amount of $30K and greater.
- **Auto-adjudicated claims –** A random selection of 1% of claims processed through the auto-adjudication process the prior day.

Audit results

Documentation of the claims quality audits includes the following test results:

- Attributes for each selected claim
- Amount of overpayment or underpayment for claims processed or paid in error
- Explanation of the erroneous processing for each claim processed or paid in error
- Determination of the source of the error
- Claims processed or paid in error that have been corrected

Each audit includes key departmental issues identified, in addition to a summary of financial and procedural accuracy. We will finalize, publish, and distribute monthly and quarterly audit results to the relevant Aetna Better Health and Aetna Medicaid departments. Audit results will be distributed to the Agency as required. These audit results will include trend reports for relevant Aetna Better Health and Aetna Medicaid departments to identify trends by error type, claims ID, and analyst ID. This data will enable Claims Management to conduct continuous quality improvement.

Resolving claims processing deficiencies

Aetna Better Health maintains policies and procedures for internal monitoring and auditing of the claims processing system. These processes strengthen the integrity of the adjudication system and minimize system exceptions resulting from changes to plan-specific programs.

We can configure over 500 system business rules to support enforcement of our claims policies and procedures. These specific conditions, restrictions, and validation criteria promote the accuracy of claims processing against Agency standards. The edits can result in claims pending or denying, depending on the selected editing logic.

The claims processing system reference files are configured by benefit year and procedure code. As the governing organizations add, terminate, or change codes, we update the codes to remain compliant with HIPAA standards and Version 5010 requirements.

Corrective actions

The Claims Quality Program identifies issues, provides root cause analysis, and suggests recommendations for corrective actions to the respective operational departments through the audit process. Departments such as Claims Operations are responsible for implementing corrective actions. These actions may include training and system changes, depending on audit findings and recommendations.

The Medicaid Provider Solution Team supports the corrective action process by monitoring issue resolution to confirm completion by responsible parties.

Attachment 5 – Section 13.4, Question 5

Describe your claims dispute procedures.

Claims dispute procedures

The Director of Provider Services and representatives under the direction of the COO are responsible for working with providers to resolve provider dissatisfaction and educate providers on how to access and use the provider dispute and provider appeal processes.

A provider may submit a claim dispute in writing by e-mail, standard mail, or fax. We can respond to the provider by fax to speed communication of the decision.

Written claim disputes must be submitted to the Aetna Better Health Appeals Department. Providers must include all supporting documentation with the initial claim dispute submission. The claim dispute must specifically state the factual and legal basis for the relief requested, along with copies of any supporting documentation, such as remittance advice, medical records, or claims. Failure to specifically state the factual and legal basis may result in denial of the claim dispute.

Aetna Better Health will acknowledge a claim dispute request within five business days after receipt. If a provider does not receive an acknowledgement letter within five business days, the provider must contact the Appeals Department. Once received, our Appeals team will review and render a decision within 30 days after receipt. We may request an extension of up to 45 days, if necessary.

If a provider disagrees with the our Notice of Decision, the provider may request a State Fair Hearing. The request for State Fair Hearing must be filed in writing no later than 30 days after receipt of the Notice of Decision.

Attachment 5 – Section 13.4, Question 6

Describe proposed processes for collaborating with other program contracts to simplify claims submission and ease administrative burdens for providers.

Simplifying claims submission for providers

Aetna Better Health of Iowa operations staff will partner with the Iowa Health Care Association to develop a program collaborative. This collaborative would work to implement and train providers on common tools, using industry solutions. These would include tools to submit claims via the web and crossover mechanisms between multiple contractors.

Attachment 5 – Section 13.4, Question 7

Propose ideas for handling Medicare crossover claims which reduce the administrative burden on providers.

Eligibility file and Medicare crossover

When we receive the HIPAA X12 834 eligibility file or the TPL Resource File we load any COB data into our business application system to update our COB data file. As a result of this process, any claim adjudicated through the system validates against the COB indicator and is processed per COB guidelines.

We also receive and process Medicare crossover claims from the Coordination of Benefits Contractor. These steps confirm that Medicare has processed the claims prior to adjudication in our systems. Using the claim crossover process, we successfully process claims for dual eligible members without denying for timely filing or authorization.

Attachment 5 – Section 13.4, Question 8

Describe processes for notifying providers of a member's financial participation or cost sharing requirements.

Notifying providers of members' cost sharing requirements

We will offer providers and members the following information about cost sharing:

- The groups of individuals subject to the premiums and cost-sharing charges
- The consequences for nonpayment
- The cumulative cost-sharing maximums
- Appropriate ways for members to make payments for the required cost-sharing charges

We will document cost-sharing information through the following sources and make these sources available to members and providers:

- **Aetna Better Health member handbook** – A description of cost sharing requirements and how to contact Member Services to answer questions.
- **Enrollment collateral** – Our collateral will include a benefit overview summarizing benefits and any related cost sharing as appropriate. Prospective members will be able to obtain information through the website and events by the Agency.
- **Aetna Better Health secure member portal** – We will post the benefit overview to our website. Members will have the option to access their specific cost sharing and patient liability information.
- **Aetna Better Health secure provider portal** – We will share member specific cost-sharing information with providers on their member panel through the secure provider portal. The portal will note that information is accurate based on the claims received and adjudicated, as there can easily be a lag in updating the cost-sharing information.
- **Member Services line** – Our members can access their cost-sharing information by calling our toll-free Member Services line and talking to a Member Services Representative.

Our provider education will emphasize that the provider cannot deny services to members based on whether they have or have not satisfied the cost-sharing requirements for a quarter.

Attachment 5 – Section 13.4, Question 9

Describe processes for providing monthly prospective reimbursement to providers of IDPH funded services.

Providing monthly prospective reimbursement for IDPH-funded services

Aetna Better Health understands that the Iowa Department of Public Health (IDPH) payment for substance use disorders services is capitated and the selected Contractor will receive a prorated amount of the annual contract for IDPH services monthly. We will submit an invoice monthly to IDPH for substance use disorders services.

We also understand that IDPH will re-procure the provider network for IDPH-funded substance use disorder treatment services, to be effective in January 2016. We will reimburse IDPH substance use disorders providers at or above the Medicaid fee schedule.

Implementation of IDPH sliding fee schedule

Monthly, we will receive the IDPH data for sliding fee amounts from the Iowa Medicaid Enterprise and load it into QNXT™, our business application and data management system. The member records in QNXT™ will store the cost-sharing amounts specific to each individual.

In adjudicating the claims for IDPH services, we will match member benefit information to provider reimbursement for services to determine adjustments to the provider's payment for substance use disorders services based on the member's ability to pay.

IDPH is the payer of last resort

We will use QNXT™ to process provider claims with IDPH as the payer of last resort. QNXT™ has system edits in place to validate situations in which members have other commercial health, casualty, workers compensation, or Medicare insurance coverage. If we discover that a member has other insurance coverage, we will document the coverage in QNXT™.

If we receive claims with an EOB attached for covered members with documented third-party liability or other insurance coverage, we will process these claims with Aetna Better Health as the payer of last resort. The system will produce a health care claim payment or advice 835 transaction for response to the provider. The COB Department will review all other payer sources for payment prior to IDPH.

IDPH participant billing and collection procedures

We will define the following IDPH participant billing and collection procedures for providers in the provider manual:

- Non-denial of services because of inability to pay
- No charge for missed appointments
- One-time, no-show fee
- Amount of no-show fee to be established by IDPH

13.5 Encounter claim submission

Attachment 5 – Section 13.5, Question 1

Describe your policies and procedures for supporting the encounter data reporting process, including:

Aetna Medicaid understands the critical role that timely, accurate and complete encounter data submission plays in Iowa's ability to continuously review the health care utilization of its Medicaid members, to analyze expenditures associated with that utilization, and to monitor service delivery performance with its partners.

Aetna Medicaid has 30 years of experience in transmitting encounter data to state Medicaid agencies with a focus on accuracy, completeness, and timeliness, as well as compliance with HIPAA and all other federal and state regulatory requirements. In serving this program, we will finalize monthly encounter data submission corrections within 45 days from the date the initial error report for the month was sent to us or 59 days from the date the initial encounter data were due. The error rate for encounter data cannot exceed 1%.

All encounter claim data will be submitted through a secure file transfer protocol (FTP) site and comply with all encounter file transmission requirements. Prior to the actual contract date, the Encounter Management Unit will review the file structure layout and contention definition requirements provided

by the Agency and work with our Aetna Medicaid IT Department to make certain that our technology standards align to those requirements. We will engage the Agency in a series of encounter data submission tests to make certain our ability to submit encounter claims successfully, and to successfully receive response files from the Agency in a secure environment.

In the following section, we describe the policies and procedures used by our Encounters Management Unit.

Attachment 5 – Section 13.5, Question 1.a

Describe your policies and procedures for supporting the encounter data reporting process, including:

A workflow of your encounter data submission process proposed, beginning with the delivery of services by the provider to the submission of encounter data to the State. If you will subcontract with multiple vendors or provider organizations for claims processing management, workflows should incorporate all such vendors, including vendor's names and the approximate volume of claims per vendor identified.

THE ENCOUNTER DATA MANAGEMENT (EDM) SYSTEM

Providers contracted to participate in our provider network shall facilitate the completeness, truthfulness and accuracy of all claims and encounter data submitted to Aetna Medicaid, including medical records data required, and make certain the information is submitted on the applicable claim form. In turn, the Encounter Management Unit will:

- Submit that encounter data to the Agency by the 20th of each month
- Support the Agency's ability to make programmatic decisions
- Support the Agency's ability to monitor compliance and quality in partnership with Aetna Better Health

Beginning with the delivery of services, we require all participating providers to submit all encounter services with the appropriate codes, including any and all capitated services. HIPAA transaction data must be submitted on the appropriate claim form within 90 days from the date of service or from the date of discharge for inpatient services.

The EDM system offers functionality to accurately and consistently track encounters throughout the submission continuum including the collection, validation, reporting, and correction of encounter data. EDM can electronically accept a HIPAA-compliant 837 (I or P) electronic claim transaction in standard format.

We require our providers and their clearinghouses to send electronic claims in this format. The EDM system processes encounter data received from any third-party contractors such as the dental, vision, and transportation vendors currently in partnership with the Agency. It also supports the most current coding protocols; for example, standard CMS procedure or service codes such as ICD-9, ICD-10, CPT-4, and HCPCS-I, II.

The EDM system accommodates all data sources and provides a central repository for the collection of claims and encounters. Through our EDM system, we conduct a coordinated set of edits and data checks and identify potential data issues at the earliest possible stage of the encounter data reporting process.

ENCOUNTER PROCESSING

QNXT™ applies a series of active claim edits to determine if the appropriate claim fields contain the required values. We can deny, completely or in part, claims submitted without required information or with invalid information. The provider must resubmit the claim with valid information before they receive payment. After adjudication and payment, we export claims data from QNXT™ into the EDM system. Our Encounter Management Unit validates the receipt of all QNXT™ claims data into EDM system using a transfer validation report. The Encounter Management Unit researches, tracks, and reports any discrepancy until that discrepancy is completely resolved.

ENCOUNTER DATA MANAGEMENT (EDM) SYSTEM SCRUB EDITS

This EDM system feature allows the Encounter Management Unit to apply Agency edit profiles to identify records that may be unacceptable to the state of Iowa. Our Encounter Management Unit can customize our EDM system edits to match the edit standards and other requirements of the Agency. This customization means we can align our encounter edit configuration with the Agency's configuration requirements to improve encounter acceptance rates and accuracy.

ENCOUNTER TRACKING REPORTS

Encounter tracking reports are another unique feature of our EDM system. Our Encounter Management Unit uses a series of management reports to monitor, identify, track, and resolve problems in the EDM system or issues with an encounter file. Using these reports, our Encounter Management Unit can identify the status of each encounter in EDM by claim adjudication date and date of service. Using these functional reports, our Encounter Management Unit can monitor the accuracy, timeliness, and completeness of encounter transactions from entry into the EDM system to submission to and acceptance by the Agency. The Encounter Management Unit also runs reports to make certain that all appropriate claims have been extracted from the claims processing system.

ENCOUNTER DATA CORRECTION

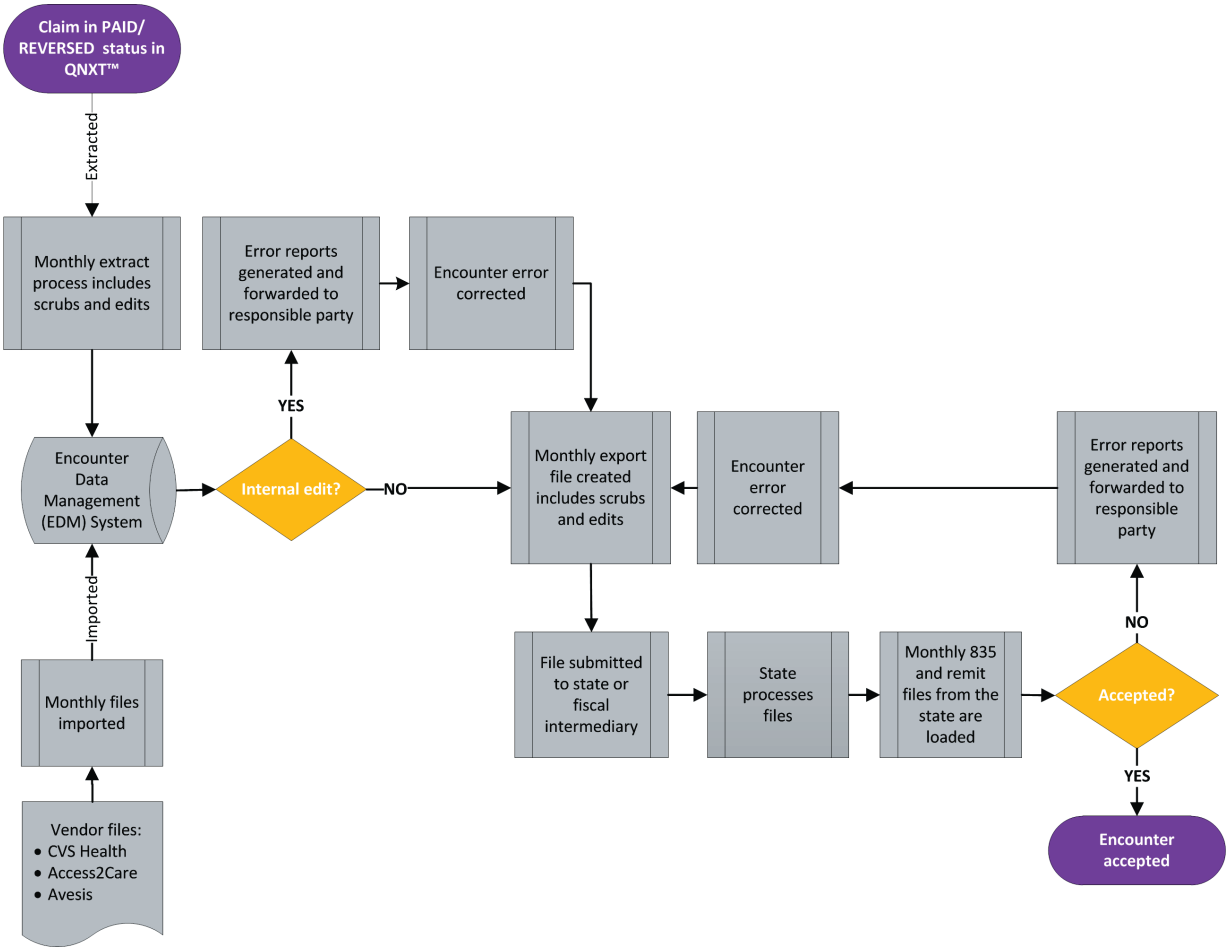
As described above, the Encounter Management Unit is solely responsible for the EDM system. This responsibility includes managing the data correction process if it is necessary to resubmit an encounter due to rejection of the encounter by the State. Our Encounter Management Unit uses two processes to manage encounter correction activities:

1. **If re-adjudication is unnecessary –** The Encounter Management Unit will make corrections to allow resubmission of encounter errors in accordance with the Encounter Management Unit's encounter correction protocol.
2. **If re-adjudication is necessary** – The Encounter Management Unit will reprocess the encounter in the appropriate claim system. The adjusted claim is then re-imported into the EDM system for resubmission to the Agency in accordance with the encounter correction protocol. The EDM system generates, as required, the appropriate void, replacement, or corrected records.

We apply lessons learned through data correction procedures to improve the EDM system scrub edits described above. As part of our continuous process improvement protocol, we will expand our EDM system scrub edits to improve our encounter submissions accuracy and minimize encounter rejections.

Figure 13-13 portrays the encounter data submissions process.

Figure 13-13: Encounter data submission process



ENCOUNTER CLAIMS WORK PLAN

The Encounter Management Unit monitors the performance outcome of its encounter data submission process daily. When we find an opportunity to improve that process, we implement steps immediately and will submit an encounter claims work plan to the Agency. This work plan will describe our strategy for monitoring and improving the encounter claims submission process.

ACCURACY OF ENCOUNTER CLAIMS

When the Encounter Management Unit is notified or determines the existence of any level of inaccuracy with the encounter claims data we submit to the Agency, we will formulate and submit an encounter claims-specific corrective action plan and implement any non-compliance remedies to make certain that we meet the Agency's standards for accuracy.

Attachment 5 – Section 13.5, Question 1b

Describe your policies and procedures for supporting the encounter data reporting process, including:

Your operational plan to transmit encounter data to the State, indicating any internal checks and balances, edits or audits you will use to verify and improve the timeliness, completeness and accuracy of encounter data submitted to the State.

Our Encounter Management Unit is important to the timely, accurate, and complete processing and submission of encounter data to the Agency. The Unit has specially trained correction analysts with experience, knowledge, and training in encounter management, claim adjudication, and claim research. This substantial skill base allows us to research and adjust encounters errors accurately and efficiently. Additionally, the unit includes technical analysts who perform the data extract and import functions, perform data analysis, and oversee and monitor the encounter files submissions to the Agency.

Another critical step in our encounter data correction process is the encounter error report. We will generate this report upon receipt of response files from the Agency, and it provides the Encounter Management Unit critical information to identify and quantify encounter errors by type and age. This data facilitates the monitoring and resolution of encounter errors and supports the timely resubmission of corrected encounters.

REPORT FORMAT AND BATCH SUBMISSION SCHEDULE

We will adhere to Agency standards outlined in Section 13.5.2 of the RFP by submitting the encounter data in a timely manner and achieving an overall encounter acceptance rate of 99% as measured by the Agency. Aetna Medicaid ensures encounter timeliness, completeness, and submission accuracy by adhering to the monitoring of workflow; we use various scheduled and ad hoc reports to monitor error inventory and resolution. A few of our standard reports include:

- **Transfer Validation Report** – This report confirms all current paid encounters are extracted from QNXT into the EDM system.
- **Flash Metric Report –** This is a global report used to monitor encounters accepted or denied by the Agency, including third-party vendors.
- **Encounter Inventory Tracking Report –** This report tracks encounter status by date of service through the EDM system until accepted or finalized.
- **Encounter Error Report –** This report provides detail level by error code used by Plan and Encounter staff to correct internal or external errors.

The Encounter Management Unit also conducts weekly meetings with management to discuss outstanding encounter issues. It also conducts weekly, monthly, and quarterly management review of encounter performance for continuous process improvement.

ENCOUNTER DATA COMPLETENESS

One of the unique features of our EDM system is the encounter staging area. The encounter staging area enables the Encounter Management Unit to evaluate all data files from QNXT™ and third party vendors for accuracy and completeness prior to loading into the EDM system. We maintain encounters in the staging area until the Encounter Management Unit validates that each encounter contains all required data and is populated with appropriate values. Our Encounter Management Unit directs, monitors, tracks, and reports issue resolution. The Encounter Management Unit is responsible for tracking resolution of all discrepancies.

Our initial Draft Encounter Claims Submission Plan (aka Encounter Implementation Plan) is provided as Appendix R for review. We will provide an official draft plan within 30 days of contract execution and a final work plan incorporating any changes requested by the Agency within 60 days of the official submission of the plan. Further, we will submit a work plan annually thereafter for the Agency's review and approval.

Attachment 5 – Section 13.5, Question 2

Describe your experience and outcomes in submitting encounter data in other states.

We are committed to meeting encounter data submission accuracy requirements

As previously stated, we understand the critical role that timely, accurate, and complete encounter data submission plays in a state's ability to continuously review health care utilization, analyze expenditures, and monitor service delivery performance. Based on our review of the past 12 months of encounter data, we have met or exceeded the submission accuracy requirements for the majority of our health plans.

In instances where we have not met or exceeded submission accuracy requirements, our Encounter Management Unit is committed to implementing a thorough corrective action plan.

Specific to the encounter accuracy submission performance for Aetna Better Health of Illinois, results took a slight downward trend due to the following issues being resolved late in November 2014:

- All federally qualified health center (FQHC) claims were held until a work order to allocate additional IT resources was implemented for a required claims fix.
- State Black Hole Error Report claims were being accepted as reversals, with a Y indicator and no error code. Our Illinois health plan has submitted a request to allocate additional IT resources specific to this issue to have these encounters accepted on the remit.
- December 2014 rate tracked at 95.96%, per the State of Illinois.

It is important to note that we are **not** at-risk of sanction with the state of Illinois. The state is aware of these issues and Aetna facilitates monthly meetings to discuss overall issue impacting encounter submission.

Specific to the encounter accuracy submission performance for Aetna Better Health of Nebraska, results continue to improve as we continue to reduce provider-related errors. We have made short-term coding updates and requested updates for the long term. While the majority of provider issues have been resolved with these updates, the Encounters Management Unit continues to resolve remaining errors. We have consistently improved our accuracy rate, month over month.

Figure 13-14 portrays our encounter data submission accuracy, by month, for the 12 months ending February 2015.

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Figure 13-14: Summary of encounter data submission accuracy by month

Encounter Submission Accuracy by Month of Submission (regardless of DOS)																		
PLAN	TARGET	TARGET SOURCE	2014 January	2014 February	2014 March	2014 April	2014 May	2014 June	2014 July	2014 August	2014 Sept	2014 Oct	2014 Nov	2014 Dec	2015 Jan	2015 Feb	2015 YTD%	12 Month Rolling %
DEL	90%	Internal	96.0%	95.1%	95.4%	98.5%	97.9%	95.9%	98.3%	98.6%	99.4%	98.92%	97.7%	99.2%	98.9%	97.3%	98.5%	98.0%
IL	90%	Internal	97.4%	80.5%	17.8%	61.3%	87.8%	87.5%	95.4%	94.7%	89.4%	86.42%	86.0%	96.0%	92.6%	95.6%	92.6%	87.0%
IL Duals	90%	Internal	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	93.0%	93.4%	N/A	93.4%	93.0%
MCA	90%	Internal	87.8%	97.2%	96.2%	98.9%	98.2%	97.7%	98.6%	98.3%	96.8%	98.56%	98.4%	91.4%	97.1%	92.8%	94.2%	97.3%
MCRP	90%	Internal	91.4%	93.7%	93.6%	96.0%	95.6%	95.3%	97.4%	98.5%	97.9%	97.13%	98.0%	97.9%	91.5%	95.5%	93.6%	97.0%
MMA	90%	Internal	N/A	N/A	N/A	N/A	N/A	N/A	99.7%	N/a	98.9%	98.65%	98.5%	99.0%	N/A	N/A	N/A	98.8%
MMIC	90%	Internal	N/a	N/a	N/a	N/a	96.9%	91.1%	95.8%	96.9%	96.3%	97.70%	94.4%	94.0%	94.3%	96.1%	95.2%	95.0%
MPC	90%	Internal	98.9%	99.1%	98.8%	98.9%	98.8%	98.4%	98.9%	99.2%	98.0%	98.26%	94.3%	98.3%	98.7%	98.5%	98.5%	98.4%
NE	95%	Contractual	N/A	N/A	N/A	N/A	N/A	N/A	N/A	87.39%	92.55%	87.28%	74.7%	84.6%	92.8%	93.1%	93.0%	87.0%
NY	90%	Internal	91.0%	88.9%	93.9%	94.4%	98.5%	94.3%	77.9%	98.2%	90.1%	85.61%	95.7%	95.7%	94.7%	96.4%	90.3%	91.3%
PA	90%	Internal	95.0%	93.6%	95.0%	95.2%	91.7%	74.0%	73.9%	77.6%	89.3%	93.76%	96.9%	95.5%	95.7%	96.8%	95.7%	91.0%
Texas - CHRISTUS	90%	Contractual	98%	99%	98%	95%	97%	96%	99%	99%	99%	99.06%	99%	99%	98%	N/A	98%	98%
Texas - Aetna Risk	90%	Contractual	98%	96%	95%	94%	96%	95%	96%	97%	96%	97.16%	97%	97%	97%	98%	98%	96%
Texas - Parkland	90%	Contractual	96%	94%	96%	95%	96%	96%	96%	98%	97%	98.31%	96%	98%	98%	97%	97%	97%
Virginia	95%	Contractual	98.0%	95.9%	85.6%	95.9%	95%	97.1%	97.5%	96.2%	97.5%	97.54%	97.4%	97.0%	95.8%	79.0%	89.6%	96.0%
2015 Total Accuracy All Plans for 2015	Total Accepted		7,263,993.00														95%	95.8%
	Total Rejected		350,107.00															
	Total Submitted		7,614,100.00															

13.6 Third Party Liability (TPL) processing

Attachment 5 – Section 13.6, Question 1

Describe your plans for coordinating benefits in order to maximize cost avoidance through the utilization of third-party coverage.

Coordination of benefits to maximize cost avoidance

We make every effort to identify situations where members have other commercial health, property and casualty, workers compensation, or Medicare insurance coverage. When we discover that a member has other insurance coverage, we document it in QNXT™, our business application system. We configure and test internal systems to support these processes and coordinate benefits. We maximize allowable recoveries and minimize recovery cost. Figure 13-16 shows the process Analysts use to load other insurance information into the claim adjudication system.

COLLABORATION BETWEEN AETNA BETTER HEALTH DEPARTMENTS

Effective use of other available sources of payment requires collaboration across multiple departments within Aetna Better Health. We involve and participate with staff in the COB, TPL, Provider Services, Claims Inquiry or Claims Research, and Member Services Departments. Through this collaborative approach, we identify other available sources of payment and capture them in QNXT™ to position the Agency as the payer of last resort. Figure 13-15 illustrates this workflow.

REPORTING PROCESS

When Aetna Better Health staff identifies a TPL resource, the employee who discovers the resource (for example, Member Services Representative or Provider Services Representative) completes a COB form and sends it to the COB Department. The COB Department compiles this information, as well as the required notifications, throughout the month for delivery to the Agency. We submit reports in the formats outlined in the Contract and transmit them in the format the Agency requires.

When our staff become aware that a member has retained counsel, the employee completes a TPL form and sends it, with related correspondence, to the TPL Department. The TPL Department documents the TPL activity in our business application and claims system and contacts our TPL vendor to start the recovery process. Figure 13-17 illustrates this workflow.

Figure 13-15: [redacted] CONFIDENTIAL

[redacted]

INTERNAL PROCESS FOR REPORTING

The three major sources of internal identification of TPL resources are:

- Other health insurance coverage identified by Agency staff, by the COB Department, or reported by the member or a provider
- Accident and casualty insurance coverage discovered by Aetna Better Health staff or reported by the member or a provider
- Tort or accident information identified by Agency staff or reported by members or their legal counsel

Health plan departments use internal forms to submit TPL resource information to the COB Department and tort or accident information to the TPL Department. This submission occurs as soon as we identify the resource. The COB and TPL Departments review the submission, facilitate updates to our business application and claims system, and prepare the required reports for submission to the Agency.

We will update the current report sent to the Agency with any additional required information on members with other insurance information.

PREVENTIVE LABOR, DELIVERY, POSTPARTUM, PRENATAL, AND PEDIATRIC CARE

We override cost-avoidance procedures, pay as primary, and coordinate with the known third-party resources for the following exceptions:

- Labor, delivery, and postpartum care that does not involve hospital costs associated with an inpatient hospital stay
- Prenatal care for a pregnant member or for preventive pediatric services that are covered by the Medicaid program

PROBABLE EXISTENCE OF LIABILITY OF A THIRD PARTY WHEN A CLAIM IS FILED

When we receive a claim for a member with documented other insurance and no remittance advice attached, we deny the claim and return the claim to the provider with instructions to submit to the other insurance entity.

We process claims with a remittance advice attached for covered members with documented other insurance coverage so Aetna Better Health is the payer of last resort.

When we receive the HIPAA X12 834 eligibility file from the Agency, we load any COB data into our business application system to update our COB database. Any claim adjudicated through the system validates against the COB indicator and is processed according to COB guidelines.

We override cost-avoidance procedures, pay as primary, and coordinate with the known third-party resources for the following exceptions:

- EPSDT services
- When the Agency enforces other insurance coverage from a parent obligated to pay support
- When the identified resources are exempt from primary payer status under Title XIX of the Social Security Act or resources provided through the state-sponsored program awarding reparations to victims of crime, as set forth in sections 2743.51 to 2743.72 of the Revised Code

Cost avoidance of these claims is prohibited, with the exception of hospital delivery claims. We attempt to recover from primary insurers on exception claims where we paid as primary when we are actually the secondary payer.

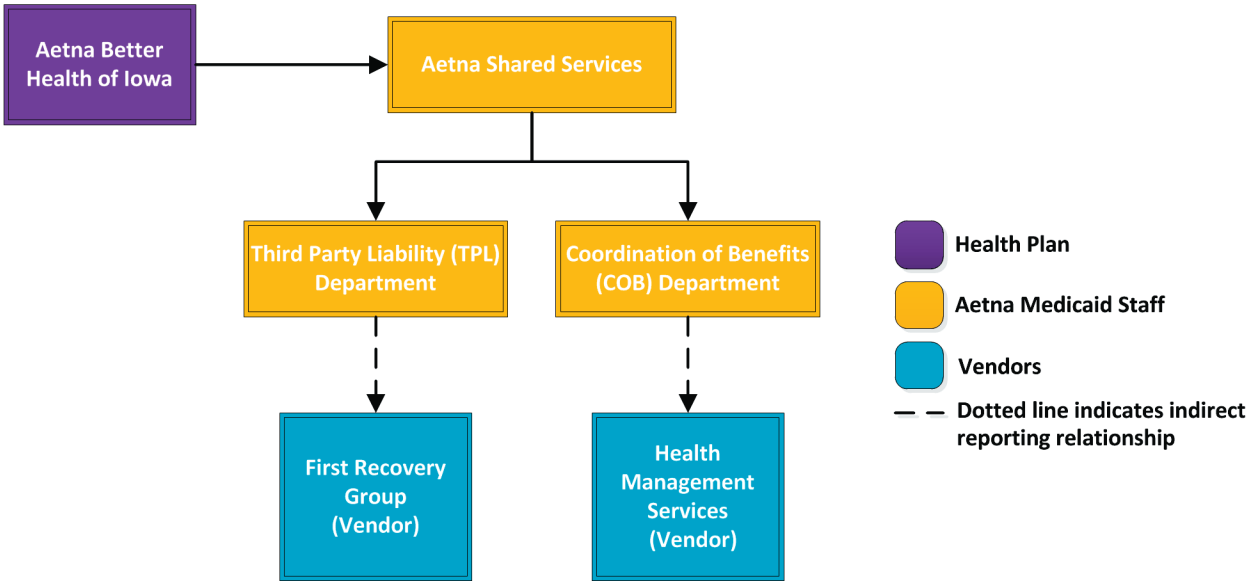
Attachment 5 – Section 13.6, Question 2

Describe your process for identifying, collecting, and reporting third-party liability coverage.

Identification of third-party coverage

Aetna Better Health directs third-party information to our COB and TPL Departments under the shared services of our affiliate and subcontractor Aetna Medicaid. Our COB or TPL Analysts adhere to written policies and procedures that maximize use of other available sources of payment and recovery. We developed these policies and procedures in accordance with federal regulations, state rules, and using Aetna Medicaid's 30 years of Medicaid managed care experience. We also have vendor relationships to provide third-party liability and coordination of benefits services. Figure 13-16 shows these relationships.

Figure 13-16: Aetna Better Health TPL or COB relationships



We begin COB or TPL efforts at the earliest point possible and educate providers on their responsibility to validate the existence of other health insurance to maximize opportunities for COB or TPL identification and recovery. Early identification of possible TPL resources improves our ability to effectively research those resources, process claims as payer of last resort, and pursue recovery of medical expenses paid. We accomplish this by using:

- Member education
- Provider orientation and ongoing training
- Collection of TPL resources
- Internal referrals and identification
- External notifications

MEMBER EDUCATION

Our Member Handbook clearly explains our members' rights and responsibilities and is available through our Welcome Packet and member portal. The responsibilities include the members' duty to

inform Aetna Better Health or another designated recovery entity, such as the Agency, of any TPL to assist in its recovery. This includes:

- Disclosing information regarding health insurance or other third-party resources upon enrolling in Aetna Better Health or upon being eligible for such benefits
- Notifying Aetna Better Health and the Agency of any health insurance obtained after becoming eligible for and enrolling in a Medicaid plan
- Notifying providers of any health and casualty coverage held and other third-party resources at the time medical care is rendered
- Notifying Aetna Better Health of any casualty or liability insurance that may cover medical treatment received due to an injury
- Executing and delivering instruments and papers needed by Aetna Better Health or the Agency in pursuit of subrogation claims
- Notifying Aetna Better Health and the Agency when filing suit against a third party
- Notifying Aetna Better Health and the Agency before entering into any settlement with a third party
- Recognizing Aetna Better Health or the Agency's rights to subrogate third-party payments that the member may receive from other payers

PROVIDER ORIENTATION AND ONGOING TRAINING

Aetna Better Health Provider Services staff train network providers about their important role in the COB or TPL process and their responsibility to identify, capture, and report COB or TPL information. Our provider orientation process, with other provider educational materials (such as the Provider Manual), includes information about our claims handling process and procedures for TPL (for example, COB and third-party recovery). We will educate network providers on and provide detailed written billing procedures for submitting claims with third-party liability for payment consideration.

Our website and provider newsletters offer provider education and training on these requirements. Provider Services Representatives educate providers during new provider orientation sessions and provider visits. Education topics include:

- Clean claims submission requirements (for example, CMS1500 and UB04 forms)
- Timeliness of claims submissions
- Claims inquiry process
- EDI requirements
- Claims payment timeframes
- Secure web portal functions and features
- COB and TPL
- Subrogation
- Review of contractual obligations regarding claims submission and related provisions (for example, HIPAA and Fraud, Waste, and Abuse)
- Responsibility to notify Aetna Better Health about other insurance or third parties liable for payment
- Responsibility to notify Aetna Better Health upon receipt of funds from third parties or other insurance entities for services paid by Aetna Better Health

Collection and recovery

Early identification and reporting of TPL resources is an important component of our cost-avoidance strategy. As we identify these resources, our staff follow our established processes to submit

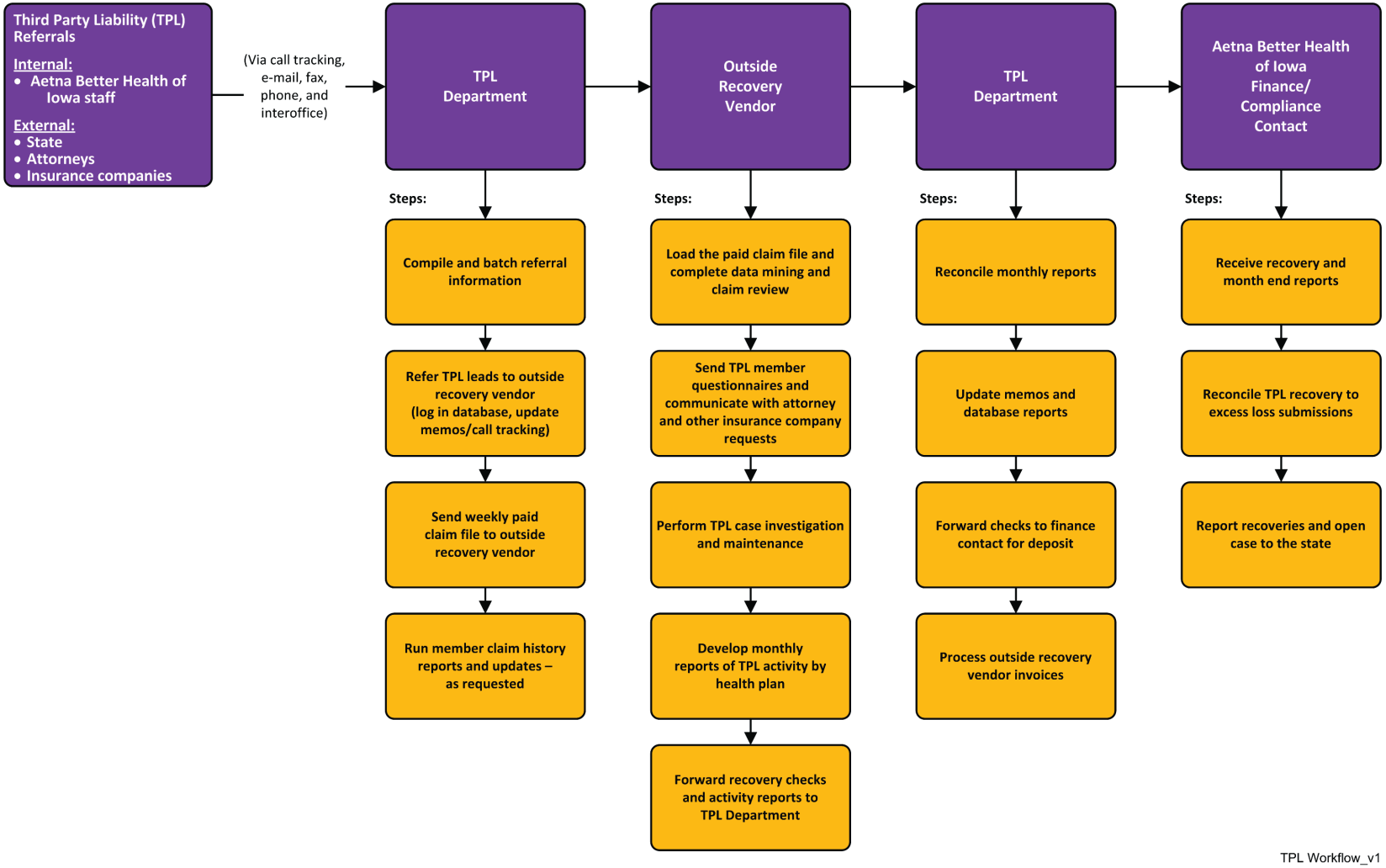
information on identified third-party information to the COB Department for reporting to the Agency. We also receive TPL information from our TPL vendor, Health Management Services (HMS).

The TPL Department is responsible for:

- Forwarding a paid claim file to the TPL vendor each week. This file identifies any claims paid by Aetna Better Health that week before determining that the member and services were covered by a third-party resource. The file will contain claims paid to confirm the presence of available information, including diagnosis and trauma codes 800 through 999.9.
- Forwarding lien and settlement requests promptly to our TPL vendor for processing and negotiation.
- Assisting the TPL vendor and Aetna Better Health in expediting and maximizing TPL recoveries.
- Forwarding TPL resource information to the COB Department promptly for claims processing and reporting to the Agency.
- Supplying monthly recovery activity and details in the required reporting format to assist Aetna Better Health in completing the monthly and quarterly reports required by the Agency and identify the recoveries to be reported as offsets to medical expense.

The TPL vendor uses additional methods such as follow-up questionnaires, database searches, courthouse searches, police reports, and health plan contacts to obtain missing information. Figure 13-18 shows the TPL workflow and steps.

Figure 13-17: TPL workflow



INTERNAL REFERRALS AND IDENTIFICATION

Our staff receive ongoing updates through departmental meetings to reinforce their responsibility in identifying and referring possible COB or TPL cases to the COB and TPL Departments using standardized forms. New-hire staff orientation also includes this training.

EXTERNAL NOTIFICATIONS

If any of our staff receive lien and claims history inquiries directly from attorneys and casualty insurance companies, they send this correspondence to the TPL Department for processing. If they receive correspondence, inquiries, or notifications regarding other health insurance, they forward this information to the COB Department for processing. Our provider network will be informed of our processes on TPL in the provider manual, which is available online.

SUBROGATION IDENTIFICATION

Aetna Better Health and Aetna Medicaid's TPL Department, along with our TPL vendor, focus on the identification and verification of other recovery opportunities, including subrogation, medical malpractice, workers compensation, personal injury, and casualty recovery.

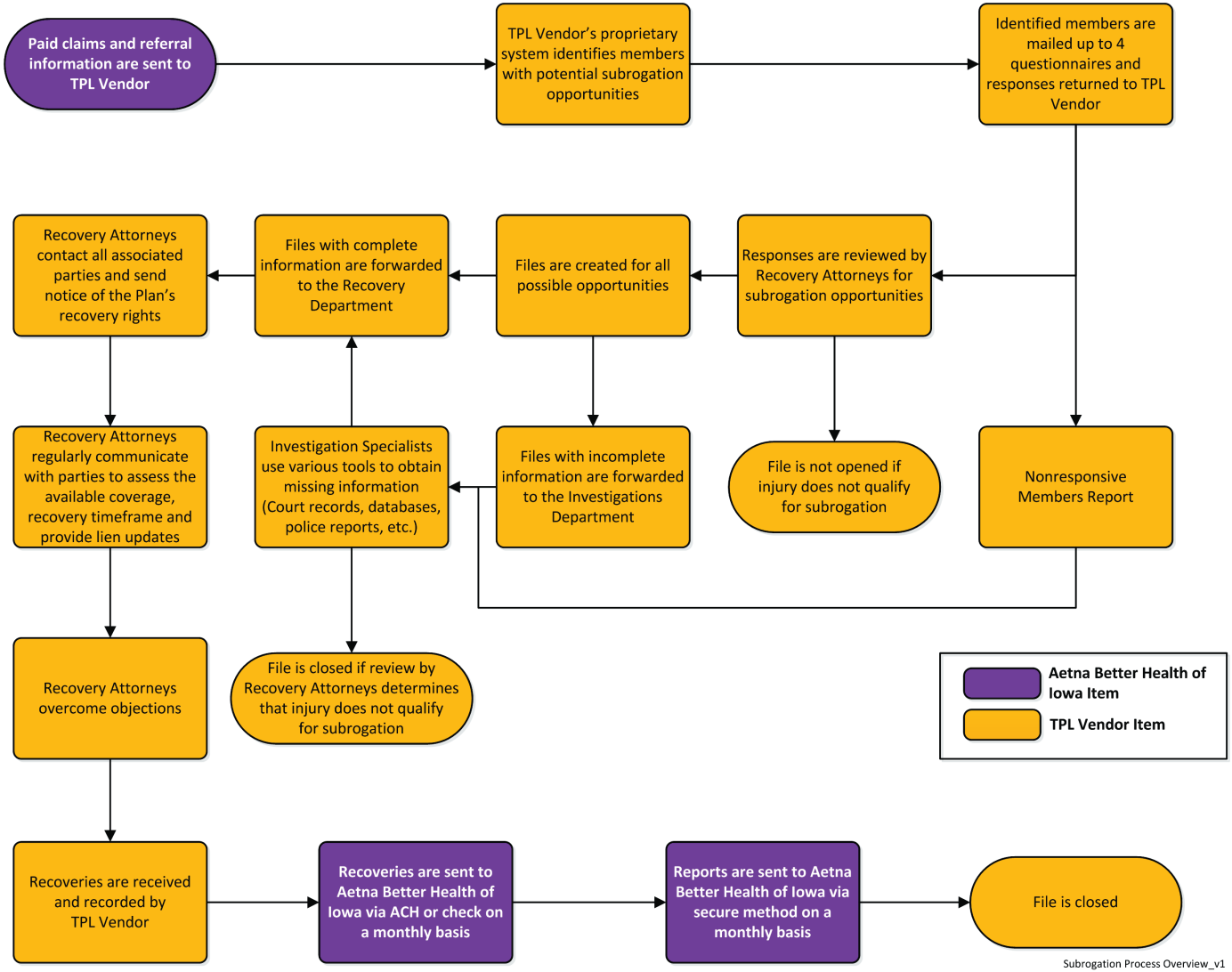
The TPL vendor provides TPL subrogation and recovery services to Aetna Better Health. Their services include investigation and identification of possible third-party liability recovery opportunities, negotiation with attorneys and casualty insurance companies, legal representation and lien filling services, case reviews, and mandatory state report generation.

We continue to maximize the recovery of third-party resources and will maintain the Agency—a Medicaid payer—as the payer of last resort for services rendered to our members. There is no dollar threshold on recoveries. We pursue all TPL opportunities.

TPL collection and recovery negotiations begin as soon as we identify third-party resources. The goal for collection activities is to collect 100% of what Aetna Better Health paid that is the responsibility of a third party, regardless of the amount believed to be available. If there are not enough funds available to cover the entire amount paid, the goal is to collect 100% of available resources to maximize the amount returned to us. When there is a compromise or negotiation required, the TPL vendor seeks our approval about an established negotiation threshold before committing to any recovery on our behalf.

Every month, the TPL vendor forwards the recoveries for the month to our TPL Department along with various internal and state-required reports. The TPL Department reviews the reports, verifies the report information matches the funds recovered, and updates the cases in the claims management system. The TPL Department then forwards the required reports to our Finance and Compliance Departments, and we produce the required monthly and quarterly reports in the Agency-required format. Figure 13-18 shows this process.

Figure 13-18: Subrogation or recovery process overview



The TPL Department confirms that we document cases the TPL Department and our TPL vendor identify and maintains this documentation in the claims management system. The TPL Department forwards TPL insurance coverage resource information to the COB Department to be reported to the Agency as required. We update the cases in the claims management system for proper claims processing for COB to confirm that the Agency is the payer of last resort.

TPL IDENTIFICATION

We identify TPL opportunities by:

- Having the TPL vendor review each weekly check run within five days after completion to identify all claims paid for that week with a diagnosis or trauma code between 800 and 999.9 and to identify claims for further review and investigation
- Matching results from the Agency to records from the Department of Labor, Division of Workers' Compensation data file
- Matching results from the Agency to records from the Iowa Highway Patrol data file
- Using a standardized internal referral form so staff members forward any possible TPL information to the TPL Department as it becomes available. This information can be as simple as an event record. For example, record could include a Prior Authorization Nurse learning of a procedure required due to a dog bite; a Claims Processor adjudicating a claim that has a code for an auto accident; a Nurse working with someone who had a slip and fall; or a Provider Services Representative assisting a provider with a claims question involving a trauma-type treatment or diagnosis.

The retroactive identification of TPL opportunities may occur as a result of correspondence and telephone calls we receive from attorneys, members, and other insurance carriers. Examples of correspondence include lien and settlement amounts or medical records information. Staff forward any correspondence and telephone calls requesting lien or medical records information to the Compliance Officer for Aetna Better Health as soon as they receive them. The Compliance Officer forwards correspondence and telephone calls that do not require special legal or appeals action to the TPL Department for processing.

INVESTIGATION TO PROMOTE TPL RECOVERY

Timely identification and investigation are critical to a successful TPL recovery program. For cases not yet identified, the investigation begins with the member. Every Monday, we forward to the TPL vendor a paid claims file containing claims paid for that week. The TPL vendor uses proprietary technology, data mining, and claims analytics to identify accident-related claims and subrogation opportunities, including review of the CMS-required code ranges. Every week, we send questionnaires to members who had claims paid that week containing possible TPL opportunities.

The TPL vendor uses additional methods such as follow-up questionnaires, database searches, courthouse searches, police reports, and provider and health plan contacts to obtain missing information and verify information. Standard and custom reporting confirm that the investigation process is thorough and complete.

When the TPL Department identifies possible recovery TPL cases, they review internal referrals, external correspondence, and information from telephone inquiries daily. The TPL department opens and documents cases in the claims management system. Every day, they forward the information available to the TPL vendor through a secure FTP connection. The TPL vendor contacts the third-party resource to begin negotiation and recovery discussions. The recovery process begins as soon as they identify

resources so that we can meet the requirement of recovery initiation within 60 days of identifying a TPL resource or coverage.

If the TPL vendor discovers other medical insurance TPL resources during their investigation, they forward these to the TPL Department for forwarding to the COB Department for processing.

Reporting

The TPL Department is responsible for forwarding TPL resource information to the COB Department promptly for claims processing and reporting to the Agency. They will also supply monthly recovery activity and details in the required reporting format to assist us in completing the monthly and quarterly reports required by the Agency and identifying the recoveries to be reported as offsets to medical expense.

Attachment 5 – Section 13.6, Question 3

Describe your process to identify members with third party coverage who may be appropriate for enrollment in the Health Insurance Premium Payment (HIPP) program.

We will alert the Agency to members we identify as potentially eligible for the Health Insurance Premium Payment (HIPP) program within an Agency-defined timeframe and method. The Agency will review these members to determine eligibility and send us any updates using the 834 file or another Agency-approved process.

We will define specific criteria and configure appropriate business rules in our TPL processes to meet the requirements of the HIPP program.

13.7 Health Information Technology

Attachment 5 – Section 13.7, Question 1

Describe your proposed healthcare information technology (HIT) and data sharing initiatives.

Committed to Health Care Transformation in Iowa

Aetna Better Health will support Iowa by building a comprehensive integrated health information technology (HIT) solution to support the new and emerging value-based and accountable care delivery and payment models. For new models to succeed in Iowa and meet the Triple Aim, technology innovation must both complement the current HIT infrastructure for the Agency and Iowa providers and assist providers in successfully coordinating care and entering into progressive risk-based arrangements. In our experience building these new models around the country, we know that success will depend upon payers and providers collaborating locally to overcome the challenge of sharing information—especially where disparate data systems often do not effectively interface or "talk" to each other. We have had success creating these dynamic information systems in our duals demonstrations, building the *Integrated Care Bridge* in Michigan, and when working with the Regional Behavioral Health Authority in Arizona to create a common platform to share member information across an expanded behavioral health network.

In Iowa, Aetna Better Health will provide industry-leading expertise and technology to seamlessly connect our network and provider continuum to deliver actionable, meaningful, and near real-time data. Our HIT solution features creating a highly collaborative approach that combines clinical and administrative workflows to form a shared, transparent approach to care coordination. These efforts will help our members receive the right care at the right place and time, while giving providers access to the information when they need it. Our HIT solution will help providers in all care settings have the

information they need to be efficient and effective at both point-of-care and with ongoing population health management.

Our HIT model in Iowa will have the following features:

- Implementation of our ***Integrated Care Technology Platform*** that will allow providers across the continuum to share common information for their attributed population. The technology allows providers to act locally with the full knowledge of the services their colleagues are providing.
- Population health management (PHM) tools and reports, such as our Iowa Health Homes profile and Quality Gaps in Care report, to support individually tailored Care Plans, and provide the capability to manage chronic conditions and total cost of care
- Technology to support seamless exchange with the Iowa Health Information Network and individual provider EHRs
- A mobile application to support providers and members with access to information while on the go or when not logged into their native EHR system
- Access to our data warehouse—the Integrated Care Engine (ICE)—that will include claims and other critical care management information
- Access to reports and information related to our proprietary risk stratification and predictive modeling tools to identify super utilizers and the highest risk members needing care and support services
- Support for providers of all capabilities and types—from accountable care organizations (ACOs) to FQHCs to Iowa Health Homes and community mental health centers—to develop appropriate shared or aligned clinical workflows and care pathways
- Support for a statewide approach that can accommodate and connect disparate systems and providers located in rural or remote locations around the state to provide seamless care and prevent duplication

Integrated Care Technology Platform: Connecting the entire provider team

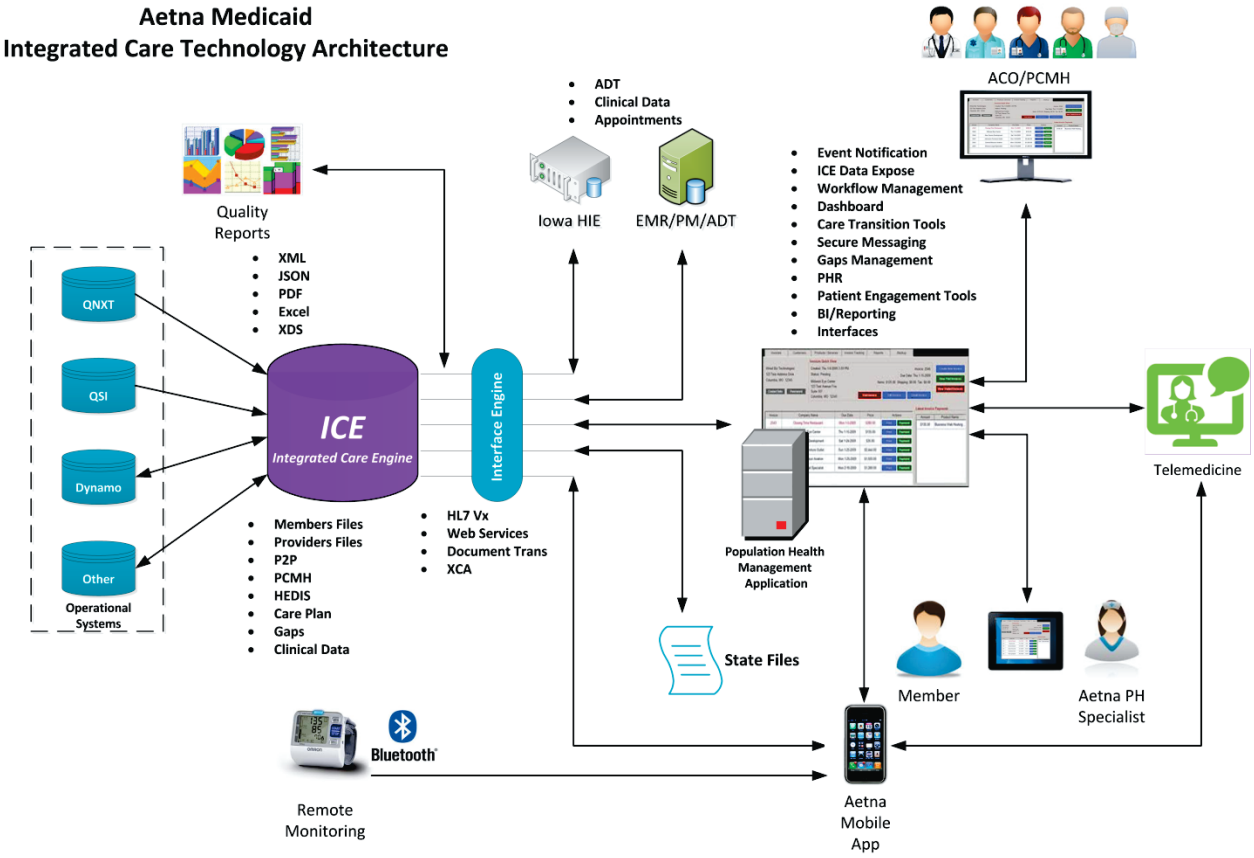
Aetna Better Health has created a comprehensive Medicaid-centric population health management technology solution called the Integrated ***Care Technology Platform*** (ICTP). The ICTP is a software application that creates a single instance to connect the entire community of healthcare providers around an individual member or group of attributed members. The ICTP serves as an air traffic control-type solution in which all information is captured to provide a common place for providers to log in to a single data ecosystem. The ICTP exposes specific clinical data, care plans, workflows, and population health management dashboards in a manner that enables the Integrated Care Team to collectively manage care for high-risk members, regardless of the care settings involved. The solution not only displays Aetna Medicaid data to provider partners, but also provides us with actionable data tied to specific, easy-to-follow workflows that foster a team approach to care.

Operating in ACO or PCMH environments, ICTP can integrate and make best use of data from EHR and PM systems to update workflows and expose holistic data to providers for a seamless experience. Likewise, the ICTP incorporates provider data into the platform, establishing a common pathway and foundation for bi-directional payer data to share with the provider community. By connecting providers directly through the ICTP, we will eliminate barriers to data exchange, care collaboration, workflow management, and communication. The solution connects providers electronically and supports clinical workflows. Its use is aimed at eliminating waste while also improving transitions of care and minimizing member visits to less efficient care settings such as the ED.

In Iowa, we will offer a pilot to support a comprehensive coordinated system of care by committing our resources to connect our ICTP with our network. Our goal is to create a local, high-functionality, technology-driven population health management platform. We will initially focus on connecting to Iowa's State Innovation Model grant, ACOs, and select FQHCs, community mental health centers, patient-centered medical homes, and Iowa Health Homes. There will be no additional cost to participating providers or the Agency for the use of this technology. This pilot will foster close collaboration with our provider partners. Collaboration will ultimately provide the collective provider network the opportunity to deliver actionable information, combined with shared, customized workflows and toolsets. wherefrom our pilot program, we will develop point-of-care best practices.

Our ICTP will also provide a more robust and enriched data source that will give providers a more complete profile of their patients, with greater visibility into the entire biopsychosocial complexity of each member. As a result, we will increase opportunities to tailor care while also promoting well-coordinated handoffs that reduce duplication of care, improve the provider level of service to members, create a better member experience, and deliver results to help meet Agency goals. This customization is a significant and necessary step to evolve the Medicaid health care delivery model from fee-for-service reimbursement to value-based care focused on quality and moving to progressive value-based arrangements. Figure 13-19 displays the general features of the ICTP and how we will connect data to our provider network.

Figure 13-19: Aetna Medicaid ICTP architecture



HIT components

In the discussion below, we introduce the key components of our HIT, including:

- ICE
- The Community Provider Interface
- Specific population health management applications and tools

INTEGRATED CARE ENGINE

Effective population health management starts with actionable, meaningful data. However, this data often exists on multiple systems where accessing the information in one place is a challenge. The ability to aggregate relevant data from multiple sources on a single platform and expose the data to the care team is essential to ensuring the care team can effectively coordinate in alignment with the member's needs and preferences.

Aetna Medicaid has created ICE to serve as our enterprise data aggregation and warehousing system. ICD is a database that holds all population health-specific data on a single platform and makes it accessible to external systems. ICE data is aggregated from several internal data sources, including our claims and care management systems. This system is based on a unified approach for organizing evidence-based data that helps healthcare providers manage members' care better. The system infrastructure applies contingency plans to provide business continuance, accessibility, scalability, and a high level of security that is HIPAA compliant.

ICE data includes:

- Member eligibility files and demographic information
- Provider networks
- PCMH, Iowa Health Home, and Pay-for-Quality reports
- Population Health Management application dashboards and tools
- HEDIS results and gaps in care
- Risk stratification and high-risk or super-utilizer member identification
- Clinical data such as medications, diagnoses, and allergies
- Care management assessment results and care plans

COMMUNITY PROVIDER INTERFACE

With different flavors of HIT and EHR systems in the marketplace, sharing information is a major challenge across multiple care settings. One solution is to deploy an interface engine with ability to connect with disparate systems and share health data in multiple formats.

Aetna's Community Provider Interface connects the Aetna Medicaid ICE system with HIT systems, including the Iowa HIE. In our recent discussions with the **Iowa Health Information Network**, we discussed options for ensuring our systems could connect immediately with the ability to securely send continuity of care data (CCD) files and ADT information. However, our Interface Engine is built to do more as a bi-directional bridge designed to transform, route, clone, and translate messages, files, and data to and from disparate systems, using standard transport protocols. The engine is designed to interface with HIEs, EMRs, practice management and other HIT systems to send, query, and receive data. The engine supports transfer protocols used across the healthcare industry including:

- HTTP
- JMS
- TCP or IP
- Web services or SOAP
- SFTP
- RTF
- HISP/Direct
- XCA

Supported data formats include:

- HL7 v.2, v.3
- CCD-A
- CCR
- X12
- Delimited text
- XML
- XDS

POPULATION HEALTH MANAGEMENT APPLICATIONS AND TOOLS

Our **ICM model** is designed to proactively engage, manage, and monitor care for population groups with complex medical, behavioral, and long-term care needs. Care coordination plays a major role in improving population health, reducing hospital readmissions, ED utilizations, and unnecessary and preventable inpatient admissions.

Our **Aetna Medicaid ICTP** is a suite of applications that enables our entire care network to collaborate with provider partners in coordinating, managing, and monitoring the continuity of care for all of our members with the ability to quickly identify and engage the highest risk, most complex members. The solution aligns health plan data and customized workflows with care transitions and member engagement tools to effectively manage care delivery for high acuity members.

The **Population Health Management** application features several useful tools, dashboards, and data sources brought together on one platform that serves as a feedback loop for the care team to support proactive, real-time, care coordination. It includes tools such as secure messaging, referrals, electronic appointment requests, interactive voice response (IVR), short message service (SMS), e-fax, workflow management dashboard, assessments, notes, gap management panel, personal health record, and remote monitoring, device biometric data. The team can then share vital information to more effectively communicate and execute on a member's care plan without duplicating care or services.

Mobile and community-based technology solutions

While we recognize technology can be viewed as complicated and confusing for many of our members, technology has improved to the point where it can now be seamlessly integrated into a member's daily life. Likewise, mobile technology has made the exchange of information between providers more timely, simple, and cost-effective. Aetna Medicaid's HIT solution will feature mobile and other virtual technology that will provide connectivity for our high-risk members to their providers and our Care Management team, while giving them the tools they need to effectively manage their care. We will:

- Incorporate the use of smartphones, tablets, and other web-enabled devices to expose appropriate clinical data, notifications, and alerts to the care team through our ICTP. This information will be shared in near real-time and tied into a dashboard and workflow so that biometric or other data can be immediately addressed and directed to the right care provider and team.
- Provide member and provider support on device and application use.
- Incorporate the use of telemedicine and telehealth technology to expand access for our members to primary and specialty care, while also supporting provider consultation—especially for rural and underserved areas in Iowa.

AETNA MEDICAID MOBILE

Aetna Inc. and Aetna Medicaid share a goal of making health care information technology more accessible and usable for all stakeholders. This goal includes electronically connecting payers, providers, and our members. A major part of our community engagement strategy is to expand the reach of our relationship with our provider network and members by promoting rapid adoption of smartphone and other mobile applications. Our approach is focused on empowering our members by providing useful information so they can stay connected with their care team, optimally self-manage their care, and make good decisions about their health.

To deliver useful information to Iowa members where and when it is needed, we will provide the Aetna Better Health app for both the iOS and Android mobile platforms. According to an IDC report released in August 2014, 96% of smartphones shipped in the second quarter of 2014 used either the Android or iOS platform, making it likely that our members will have a device that can run the app. These platforms support both phone and tablet devices.

Available free from the Apple App Store and Google Play, the bilingual application will include all key functions needed for members. A secure log in protects the user's health information and personal data and unlocks user-specific functions and updates. The app is customized to reflect the benefits available in Iowa.

By delivering a single app, we offer several other benefits as well:

- **Members need only search for one app for their device.** Other healthcare organizations often have multiple apps available for each market and program, making it harder to know which app to select and install.
- **Just as Iowa will benefit from innovations developed in the future** for other Aetna Medicaid markets, other Aetna Medicaid markets will benefit from innovations developed for Iowa.

We will use our communications with members to encourage them to access their health information through this convenient, portable format. The member handbook and other printed member materials will describe the app and we will promote the app on the publicly accessible part of the Aetna Better Health website. As we make welcome calls and answer member services calls, we will ask members if they know about the app and we will explain how to get it, if necessary. Our Community Outreach staff will mention the app when they attend health fairs and other community presentations. Provider Services Representatives will encourage providers to tell their patients who are Aetna Better Health members about the app.

[redacted] **- CONFIDENTIAL**

[redacted] **- CONFIDENTIAL**

Figure 13-20: [redacted] ***- CONFIDENTIAL***

[redacted]

The ultimate goal of the Aetna Better Health mobile app is to engage members and providers to actively manage their care. We understand that having a simple and easy-to-use app can help our members and their families navigate the healthcare system, giving them instant knowledge and information that empowers them. We developed the mobile app with simplicity in mind. The app enables members to easily access relevant information and navigate different screens with minimal effort.

TELEMEDICINE/TELEHEALTH

As part of our comprehensive HIT solution and network offering, Aetna Better Health will provide telemedicine and telehealth technology capabilities that will offer our members another venue to access care. We will work with our network and existing telemedicine providers in rural locations to enable practitioners to evaluate, diagnose, and treat patients remotely using the latest telecommunications technology. There are many benefits to telemedicine:

- Patient access to expert medical care without having to travel
- Cost-efficient, expert consultations for rural practitioners using telemedicine products to capture and transmit medical data and images to peers and specialists
- Opportunities to cover gaps in care, such tele behavioral health services for a PCMH

The ICTP can display care notes and other clinical information resulting from telemedicine visits or telehealth consults. By making this data available to the entire care team, we can prevent duplication of services and make certain the care team can view and incorporate changes to member Care Plans into each member's treatment plan.

Our telemedicine partner will be able to facilitate real-time consultation between a patient and their medical provider using a smartphone application. We are in the design process for being able to facilitate the in-person communication via the ICTP and capturing the outcomes and visit note data on the ICTP. We believe that over the next two to three years, the melding of mobile technology will

provide powerful tools members can use on-demand in the community setting. Aetna is committed to building on the current provider telemedicine and telehealth network and expanding our ability to further integrate care, align services in the community, and provide an evidence-based approach to incorporating telemedicine as a standard clinical practice model.

REMOTE MONITORING

In most care settings, visibility into members' health condition and insight into gaps in their ability to self-manage typically only surfaces when the member is in for a scheduled primary care visit, visits the ED, or is admitted to the hospital. As part of our comprehensive HIT strategy, we will offer our standard remote monitoring **Safe-at-Home** package for select members with chronic conditions. Our program offers the latest in remote monitoring and sensor technology to help provide members and providers the information they need to successfully self-manage and to focus on early warning identification and prevention. The technology also fits into our post-acute care strategy after hospitalization.

By providing timely information about a member's care interactions, customized workflows, and tools, we help improve quality and outcomes. We improve by:

- Making it possible to more accurately measure what has been done
- Clarifying the impact of measures to providers
- Informing decisions about what needs to be done next
- Identifying and executing more useful clinical quality improvement initiatives

Improved access, timeliness, and accuracy of medical records make HEDIS rates and other measurements more complete and thus more accurate, without the expense and provider burden created by requesting more medical record reviews. Aetna Better Health views improved access, timeliness, and accuracy of medical records as an opportunity to provide our members' peace of mind with a direct line to their health team should their health status change.

Another benefit of providing access to remote monitoring technology is another layer of security for members living in rural or underserved areas, ensuring their care is being well managed and closely monitored. While we see many applications for our remote monitoring technology, we will focus our early efforts on individuals who are at the highest risk and have a history of poorly controlled diabetes, congestive heart failure, hypertension, and chronic obstructive pulmonary disease. We will also examine the opportunity to focus on high-risk pregnancy.

Aetna will bring to the market our tailored, in-home monitoring solutions that can be easily deployed and which support the Agency's vision with driving to the triple aim. As part of our HIT strategy, we will aggregate and deliver biometric and other associated data through the ICTP. The care team can see discrete pieces of actionable information and alerts in near-real time. We will tie this information into a dashboard and workflow protocol so we can immediately address any abnormal value and direct it to the right care provider and team. Further, we will educate members on how to notify their provider care team or Care Manager should an abnormal value arise or should they need guidance on managing a change in condition. Table 13-4 shows our Integrated Care Technology Platform (ICTP) component summary.

Table 13-4: Integrated Care Technology Platform (ICTP) component summary

Technology component	What it enables	What it does
Integrated Care Engine (ICE)	Aetna Medicaid internal data aggregation, warehousing, and integration engine	• Aggregates data from multiple internal systems. Generates reports and provides multiple layers of data transport to providers and HIEs, EMRs and other HIT systems.
Event notification system	Advanced logic and powerful algorithms to deliver timely, automated, user-controlled, event-based notifications as they happen throughout the network	• Improves the quality, safety, and efficiency of care while reducing disparities • Facilitates quick engagement with members after acute event
Care Team Connect	Maps a logical connection between care team members	• Creates a connected community of Aetna Population Health Specialists and healthcare providers based on members' eligibility and credentials • Improves the quality, safety, and efficiency of care while reducing disparities
Data exposure	Exposes meaningful data to the care team from number of different data sources	• Provides 360-degree view of patient data, risks score, gaps, care plans, HEDIS, and lot more on a single platform
Workflow management and dashboard	Customized Medicaid processes and best practice workflow management with dashboard	• Provides care team with standard and customized processes to manage gaps and navigate high-risk members through multiple care settings • Gives a view of patient status to the entire care team • Enables the care team to perform and manage tasks related to patient risk factors and desired outcomes
Business Intelligence	Data analytics and reporting	• Delivers an intelligent view of patient data • Analyses data to find the best workflow for member's condition • Provides an array of reporting options
Secure communication	Secure e-mail/Direct, IVR, SMS, e-fax, e-referrals, e-transport	• Provides the care team with all the tools necessary to commutate, collaborate, manage referrals and share information • Enables the care team to communicate, share information and engage members' • Gives Care Managers tools to request transportation and other services for members
Telehealth	Remote access to face-to-face physician consults	• Face-to-face delivery of care by smartphone app or secure web portal • Enables members in rural areas to access care • Provides quick action in support of integrated healthcare delivery
Remote monitoring	Monitoring and transmission of vital biometric data of high-risk members	• Collects data from leading monitoring devices through member's smartphone • Analyses data and alerts care team of potential problems • Exposes data to the care team using the ICTP provider portal

Population health management and quality profiles and reports

For all participating providers, Aetna Better Health will deliver our specialized quality reports and profiles monthly using our ICTP. Included in the suite of reports will be our ACO, PCMH, and Integrated Health Homes profile reports, as well as our Quality Gaps in Care reporting, which will support point-of-care clinical decision making and overall quality, population health, and chronic disease management efforts.

The profile features the following information:

- Member data with specific information tied to each member's Individualized Care Plan, disease conditions, and caregiver considerations that can be easily integrated into the provider's clinical workflows
- Specific clinical and quality member information delivered at the individual provider, practice, and plan levels
- HEDIS, Pay for Quality, and other quality information, along with member intervention lists that include gaps in care, that empower the PCMH team to develop outreach plans for specific measures focused on prevention
- Readmissions and care transition information, including hospital discharge
- Utilization and cost trends, including PCP, specialist, pharmacy, inpatient, and ED
- Predictive modeling and member risk assessment to identify the most vulnerable and highest-risk members, with specific inpatient and ED risk scores to identify those at highest risk for readmission
- Health risk assessment results
- Care Delivery reports for insight into care team performance and details about member care transition tasks, timing, and outcomes and member engagement through multiple care settings

ICTP ADOPTION AND POPULATION HEALTH MANAGEMENT SUPPORT

Given the broad set of tools we will offer to our Iowa provider network, we know that providers across the continuum will have various capabilities and existing HIT system infrastructure. While we will focus on supporting providers participating in the State Innovation Models grant and associated ACO networks, we are committed to bringing the tools and technology to the entire provider continuum. To facilitate our platform adoptions and tool use to coordinate and manage our members' health, we will use a **Clinical Integration Team** to support providers. Further, as we look to continuously innovate our offering in Iowa, we have the resources of our national iSolutions, IT, and Informatics teams to support the local Plan with developing, maintaining, and operationalizing the technology and future iterations.

Attachment 5 – Section 13.7, Question 2

Describe how you propose to interface with the Iowa Health Information Exchange.

The Iowa HIE plays a major role in Aetna's overall population health management strategy. Timely access to ADT and other clinical data on the Iowa HIE, in combination with our internal data and clinical workflows, can make a profound impact on reducing hospital readmissions, ED utilizations, and improving the health of our members. Our health plans in other states have a long history of integration with HIE platforms and fully understand the technology, processes, and requirements.

One example of our progress and investment toward HIE is in Louisiana, where the Louisiana Department of Health and Hospitals has placed a priority on leveraging the Louisiana HIE (LAHIE). Working with LAHIE, we have started the process of connecting and receiving hospital ADTs and ED registry data. In the coming months, we are on target to advance the process:

- **Step One: June/July –** The first step of the process in Louisiana is to align our members' eligibility files, create a standard connection, and transport the files in a workable format. We will then use the same connection to start receiving HL7 ADT data from a number of hospitals in addition to ED admissions data. The data will be pushed in flat files to us every 12 hours and passed on to ICTP. We will translate the HL7 data in these flat files and convert them into transactions and alerts.

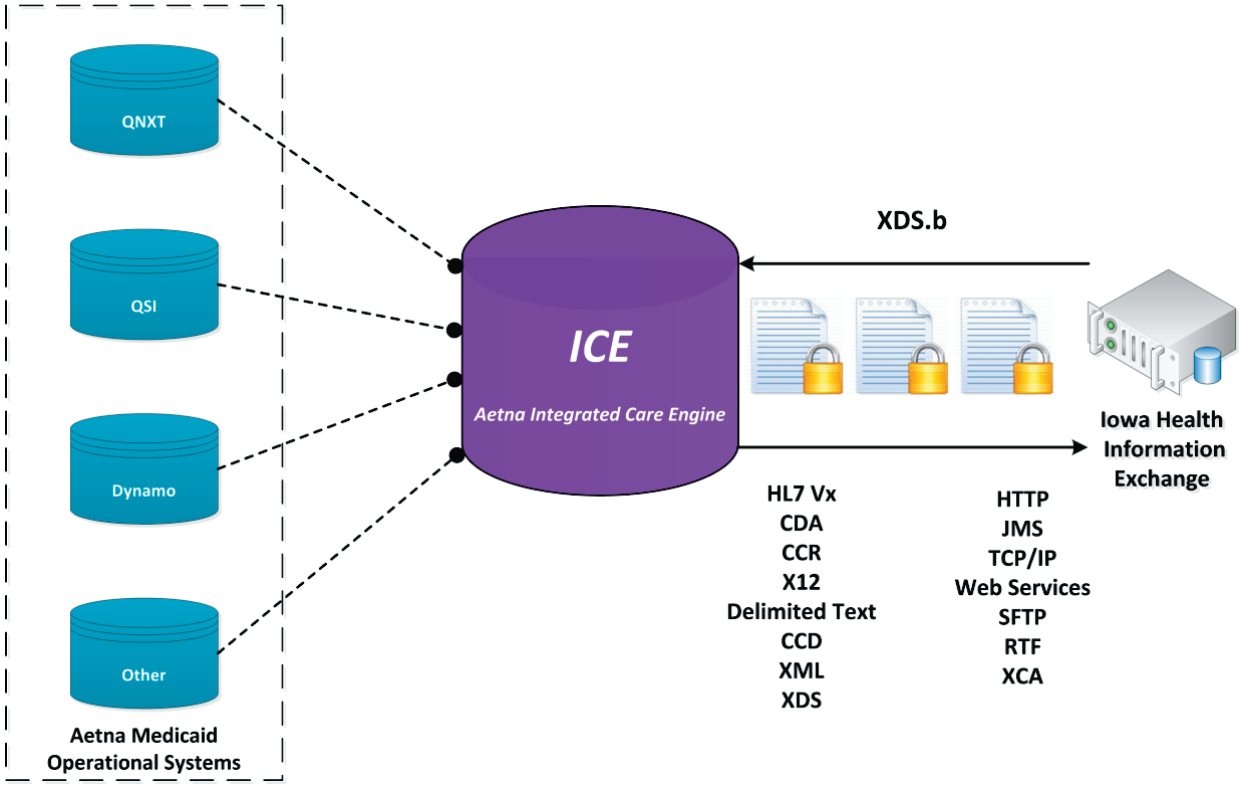
- **Step Two: November/December –** The second step of the process is to establish HL7 engine connection from which the data will be received and passed on to ICTP in real time.

In later phases in Louisiana, we plan to enhance this process to receive clinical data, including results, summaries, radiology, lab work, and more.

INTERFACING WITH IOWA

The Aetna ICE system can connect with the Iowa HIE through its XDS.b- and RLS-capable system. By connecting directly to the Iowa HIE through web services and the XDS.b or XCA protocol, Aetna can also push members' eligibility files, provider lists, and other information to identify the right members and providers on the HIE. Through the same bi-directional connection, ICE can receive ADT data, as well as clinical data to support clinical workflows aimed at improving transition of care, minimizing hospital readmissions, and reducing ED utilizations. ICE is capable of connecting to the Iowa HIE by other secure protocols such as HTTP, JMS, TCP/IP, Web Services (SOAP), (S) FTP, or RTFs. Figure 13-21 displays the Integrated Care Engine (ICE).

Figure 13-21: Integrated Care Engine (ICE) provides a bi-directional connection to Iowa's HIE



In a situation where the Iowa HIE might not be ready for integration and data exchange with ICE, we can receive ADT and other data directly from hospitals as a short-term solution. Our system can even receive and ingest HL7 messages in a flat file. Another short-term alternative is to use members' prior authorizations to initiate hospital encounter notifications to the care team. With having flexibility and several methods of acquiring needed data, our ICTP will fully complement the Iowa HIE. While the Iowa HIE provides meaningful data to healthcare providers, the Aetna ICTP turns data to action with measurable outcomes. We will:

- Provide resources and subject matter experts to facilitate integration with Aetna Medicaid systems.
- Enable Aetna Better Health providers in the state to access our advanced Population Health Management platform in combination with data from the Iowa HIE. This combination will be a significant incentive for providers to join our network.
- Demonstrate the benefits of an integrated model of care management with the Iowa HIE to facilitate communication, collaborate, and share information among stakeholders.
- Train provider staff and care team members on how to use Aetna Medicaid tools and applications. There will be no cost to providers for joining the program.
- Evaluate the pilot by obtaining and analyzing feedback from members, providers, Aetna Better Health and Aetna Medicaid staff, and the Agency. We will evaluate after one full year of operations. Our goal is to enroll Aetna Better Health providers and provide them the right tools to actively manage the health of the population. We believe that we can achieve a critical mass of participating providers by February 1, 2017, within two years of the start date of operations.

Our mission and tools, combined with the Iowa HIE capabilities will help providers and patients to be more engaged in producing quality outcomes. Providers who are connected can use our infrastructure for all of our members; our approach is EHR-agnostic.

We will support, maintain, and update our Population Health Management application infrastructure and connection with the Iowa HIE to proactively manage continuity of care through multiple care settings. In later phases of implementation, Aetna can consume additional relevant data from the Iowa HIE to manage care better for the population, while providing the Iowa HIE additional data to be shared with healthcare providers.

We can securely exchange data with the Iowa HIE using HL7, web services, or document exchange standards. The Aetna ICTP can also receive and consume HL7 messages and documents in flat files.

Attachment 5 – Section 13.7, Question 3

Describe HIT initiatives you have implemented in other states.

Aetna Medicaid invests heavily in technology and partnership with multiple states to better manage members' health and well-being. The HIT initiatives include a comprehensive population health management solution for our integrated care model.

- **Arizona –** Connecting with the Arizona HIE and state behavioral HIE to retrieve ADT and clinical data for members. The data is analyzed by Aetna informatics engine to stratify risk. Additionally, the relevant ADT and clinical data will be exported to Aetna Integrated Care Technology Platform. The ADT and clinical data will be combined with Aetna claims data as well as informatics reports and made available to providers and the care team. The ICTP system notifies the care team of high-risk members' acute encounters, assigns the best workflow to the member, shares data and helps the care team to coordinate, manage and monitor members' transition of care and gaps in care.
- **Ohio, Michigan** – By connecting with state HIEs, Aetna Medicaid receives ADT notification to be consumed by the Medicaid care management system. This information enhances care management for members. In addition, leveraging ICE, Michigan HIEs receive and ingest Aetna Informatics reports, Care Plans and other claims-related data to support value-based contracting. To better coordinate care for members, the data is visible in the HIE portal and sent to providers through direct messaging. ICE has interfaced with a third-party system to receive and analyze referrals for members, which includes operational reporting in addition to referrals status, length of time to complete referrals, updates, and more.

- **Louisiana –** Connecting with LAHIE to facilitate care transitions for high-risk members. The initiative follows the same path as Arizona in which Aetna's ICTP, in concert with LAHIE and Aetna internal resources create a holistic population health management solution for providers and members.
- **Nationally** – Aetna is rolling out the Aetna Better Health mobile application to 11 states. The mobile application is customized and configured to address the needs and requirements of members managed by each health plan.

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Section 14: Performance Targets and Reporting Requirements

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SECTION 14 – PERFORMANCE TARGETS AND REPORTING REQUIREMENTS

The table below outlines how the Scope of Work provided in RFP Attachment 1 relates to the responses to the questions provided in RFP Attachment 5. We provide this table to reduce redundancy of responses and information and to simplify the evaluation process for the evaluators.

For requirements in Attachment 1 that do not require a detailed response, the table below indicates our intent to comply with the stated requirement in lieu of repeating the RFP question and including a will comply statement within the body of the narrative.

Attachment 1 requirement	Cross reference to Attachment 5	Will comply
14.1 General	Attachment 5 - Section 14, Question 1	Yes
14.1.1 Reporting Requirements	Attachment 5 - Section 14, Question 1	Yes
14.1.2 Audit Rights & Remedies	Attachment 5 - Section 14, Question 1	Yes
14.1.3 Meeting with the Agency	Attachment 5 - Section 14, Question 1	Yes
14.1.4 Implementation Reporting	Attachment 5 - Section 14, Question 1	Yes
14.1.5 Other Reporting and Changes	Attachment 5 - Section 14, Question 1	Yes
14.2 Financial Reports & Performance Targets	Attachment 5 - Section 14, Question 1	Yes
14.2.1 Third Party Liability Collections	Attachment 5 - Section 14, Question 1	Yes
14.2.2 Iowa Insurance Division Reporting	Attachment 5 - Section 14, Question 1	Yes
14.2.3 Annual Independent Audit	Attachment 5 - Section 14, Question 1	Yes
14.2.4 Physician Incentive Plan Disclosure	Attachment 5 - Section 14, Question 1	Yes
14.2.5 Insurance Premium Notice	Attachment 5 - Section 14, Question 1	Yes
14.2.6 Reinsurance	Attachment 5 - Section 14, Question 1	Yes
14.2.7 Medical Loss Ratio	Attachment 5 - Section 14, Question 1	Yes
14.3 Member Services Reports & Performance Targets	Attachment 5 - Section 14, Question 1	Yes
14.3.1 Completion of Initial Health Risk Screening	Attachment 5 - Section 14, Question 1	Yes
14.3.2 Completion of Comprehensive Health Risk Assessment	Attachment 5 - Section 14, Question 1	Yes
14.3.3 Care Plan Development	Attachment 5 - Section 14, Question 1	Yes
14.3.4 Member Helpline Performance Report	Attachment 5 - Section 14, Question 1	Yes
14.3.5 Member Enrollment and Disenrollment	Attachment 5 - Section 14, Question 1	Yes
14.3.6 Member Grievances Report	Attachment 5 - Section 14, Question 1	Yes
14.3.7 Member Hearing and Appeals Report	Attachment 5 - Section 14, Question 1	Yes
14.3.8 Summary of Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey	Attachment 5 - Section 14, Question 1	Yes
14.3.9 Member Website Utilization Report	Attachment 5 - Section 14, Question 1	Yes
14.3.10 Member PCP Assignment Report	Attachment 5 - Section 14, Question 1	

Attachment 1 requirement	Cross reference to Attachment 5	Will comply
14.4 Provider Network Reports & Performance Targets	Attachment 5 - Section 14, Question 1	Yes
14.4.1 Network Geographic Access Reports for Providers	Attachment 5 - Section 14, Question 1	Yes
14.4.2 Twenty four (24)-Hour Availability Audit	Attachment 5 - Section 14, Question 1	Yes
14.4.3 Provider Credentialing Report	Attachment 5 - Section 14, Question 1	Yes
14.4.4 Subcontractor Compliance Summary Report	Attachment 5 - Section 14, Question 1	Yes
14.4.5 Provider Helpline Performance Report	Attachment 5 - Section 14, Question 1	Yes
14.5 Quality Management Reports & Performance Targets	Attachment 5 - Section 14, Question 1	Yes
14.5.1 Quality Management and Improvement Program Work Plan	Attachment 5 - Section 14, Question 1	Yes
14.5.2 Quality Management Committee Meeting Minutes	Attachment 5 - Section 14, Question 1	Yes
14.5.3 Care Coordination Report	Attachment 5 - Section 14, Question 1	Yes
14.5.4 HEDIS Report	Attachment 5 - Section 14, Question 1	Yes
14.5.5 Quarterly Health Outcomes and Clinical Reports	Attachment 5 - Section 14, Question 1	Yes
14.5.5.1	Attachment 5 - Section 14, Question 1	Yes
14.5.5.2	Attachment 5 - Section 14, Question 1	Yes
14.5.5.3	Attachment 5 - Section 14, Question 1	Yes
14.5.5.4	Attachment 5 - Section 14, Question 1	Yes
14.5.5.5	Attachment 5 - Section 14, Question 1	Yes
14.5.5.6	Attachment 5 - Section 14, Question 1	Yes
14.6 LTSS Reports & Performance Targets	Attachment 5 - Section 14, Question 1	Yes
14.6.1 Nursing Facility Admission Rates	Attachment 5 - Section 14, Question 1	Yes
14.6.2 Nursing Facility Days of Care	Attachment 5 - Section 14, Question 1	Yes
14.6.3 Return to Community	Attachment 5 - Section 14, Question 1	Yes
14.6.4 ICF/ID and PMIC Report	Attachment 5 - Section 14, Question 1	Yes
14.6.5 Fall Risk Management	Attachment 5 - Section 14, Question 1	Yes
14.6.6 Hospital Admission after Nursing Facility Discharge	Attachment 5 - Section 14, Question 1	Yes
14.6.7 Self-Direction	Attachment 5 - Section 14, Question 1	Yes
14.6.8 Timeliness of Level of Care	Attachment 5 - Section 14, Question 1	Yes
14.6.9 Timeliness of Needs Assessment and Reassessments	Attachment 5 - Section 14, Question 1	Yes
14.6.10 Care Plan & Case Notes Audit	Attachment 5 - Section 14, Question 1	Yes
14.6.11 Critical Incident Reporting	Attachment 5 - Section 14, Question 1	Yes
14.6.12 Out of State Placements	Attachment 5 - Section 14, Question 1	Yes
14.7 Quality of Life Reports & Performance Targets	Attachment 5 - Section 14, Question 1	Yes
14.8 Utilization Reports & Performance Targets	Attachment 5 - Section 14, Question 1	Yes
14.8.1 Program Integrity Plan	Attachment 5 - Section 14, Question 1	Yes

Attachment 1 requirement	Cross reference to Attachment 5	Will comply
14.8.2 Prior Authorization Report	Attachment 5 - Section 14, Question 1	Yes
14.8.3 Pharmacy Rebate Reporting	Attachment 5 - Section 14, Question 1	Yes
14.8.4 Pharmacy Reporting	Attachment 5 - Section 14, Question 1	Yes
14.9 Claims Reports & Performance Targets	Attachment 5 - Section 14, Question 1	Yes
14.9.1 Adjudicated Claims Summary, Claims Aging Summary and Claims Lag Report	Attachment 5 - Section 14, Question 1	Yes
14.9.2 Claims Denials Reasons	Attachment 5 - Section 14, Question 1	Yes
14.10 CMS Reporting	Attachment 5 - Section 14, Question 1	Yes
14.11 IDPH Reporting	Attachment 5 - Section 14, Question 1	Yes

14.1 Introduction

Please explain how you propose to execute Section 14 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Successful performance reporting depends on flexible reporting tools, powerful analytics, and access to up-to-date, comprehensive data and metrics.

Stability, Competency, and Trust in the Face of Challenge

Aetna Better Health of Iowa Inc. will apply the data and analytics infrastructure and processes we use in 17 states to meet the Iowa Department of Human Services' specific reporting needs. Our health plans produce standardized monthly, quarterly, semi-annual, and annual reports according to contract requirements, as well as a variety of reports on an as-needed or as-requested basis. Through the support of Aetna Medicaid's specialized Informatics Team, Aetna Better Health can also recommend and develop custom reporting to suit the Agency's new and emerging needs.

Successful Medicaid reporting relies on data availability, integrity, and transparency:

- **Availability –** Automated and ad hoc reporting made available through our advanced reporting engine, care management system, and QXNT™ business application and data management system and Informatics staff, which creates value by expanding the range of actionable information for the states we serve.
- **Integrity –** A reporting process that relies on internal validation and certification of data accuracy before delivery to the Agency.
- **Transparency –** A rich array of up-to-date performance data and analytics derived from Actuarial Services, Compliance, Enrollment, Finance, Information Technology, Long Term Services and Supports (LTSS), Medical Economics, Member Services, Provider Services, and Quality Improvement, with deliverables consistently documented and tracked in the Compliance Report Catalog, a report-tracking application.

We focus on producing timely, accurate, and compliant reports to help the Agency make informed decisions and promote its goals of providing high-quality, cost-effective, and integrated care to members.

Attachment 5 – Section 14, Question 1 (SOW 14.1. 14.2, 14.3, 14.4, 14.5, 14.6, 14.7, 14.8, 14.9, 14.10, 14.11)

Describe your plan to provide the reports described in the RFP, in the format required, and using templates that may be specified in the Reporting Manual and updated from time to time.

Timely, accurate reporting

The combination of our tools, data, analytic capabilities, and planned staffing will enable us to meet reporting requirements in the new Contract. All submitted data will be certified as specified by the Agency.

Our reporting process requires three essential elements:

- Informatics staff, supported by the capabilities of the Aetna Medicaid Informatics Team
- Our reporting engine
- Our data sources

INFORMATICS ANALYST STAFF

A dedicated Informatics Analyst will be responsible for aggregating clinical and financial health care data from multiple sources to generate reports and manage datasets that support Agency performance monitoring and emerging initiatives. The Informatics Analyst produces results such as lists, reports, graphical summaries, statistics, and statistical analyses.

The Informatics Analyst serves in a problem-solving role that collaborates with the full range of services across Aetna Better Health, including Actuarial Services, Compliance, Enrollment, Finance, Information Technology, LTSS, Medical Economics, Member Services, Pharmacy, Provider Services, and Quality Improvement.

The Informatics Analyst also collaborates with the Aetna Medicaid Informatics team, which creates value by expanding the range of actionable information for the states we serve through both standard and highly customized reporting. The Informatics Team executes complex data queries, integrates health care data from multiple sources, and applies appropriate research and statistical methods to help internal and external decision-makers assess health and economic outcomes, including utilization measures, quality, and cost data.

THE REPORTING ENGINE

Our primary reporting tool is the Analytical Services Database (ASDB), decision-support and informatics solution that powers Consolidated Outreach and Risk Evaluation (CORE), QualityCore, HEDIS, EPSDT, and care gaps reporting. Because this system supports reporting and analysis, such as multidimensional predictive modeling and statistical outlier analysis, we use it as our primary reporting tool. The ASDB contains information received from various applications such as QNXT™ (our business application and data management system and the core of Aetna Medicaid's application architecture) and our case management applications. The ASDB also serves as a key data source for our diverse user base, including Medical Management, Finance, and Operations. We will update pharmacy data from CVS Health (our pharmacy subcontractor) in the ASDB monthly to support pharmacy reporting requirements. CVS Health will be able to report pharmacy data directly out of its system.

Agency and local Aetna Medicaid analysts will use a proprietary Visual Basic interactive interface, Actuarial Analytics Web Portal (AAWeb), as a point-and-click query tool to access reports, navigate data sources, and export information from ASDB. This interface offers:

- Customized analyses to identify favorable and unfavorable cost and utilization trends
- Performance against key benchmarks
- Summary information

This enables us to disseminate the results of our analyses of treatment best practices to providers. Providers then can identify and prevent unnecessary migrations to higher levels of care and attempt to prevent members from acquiring chronic health conditions.

DATA SOURCES

The reports we will produce to satisfy the Agency requirements use data from all areas of the health plan. We will store and maintain the data needed to examine our operations from any angle.

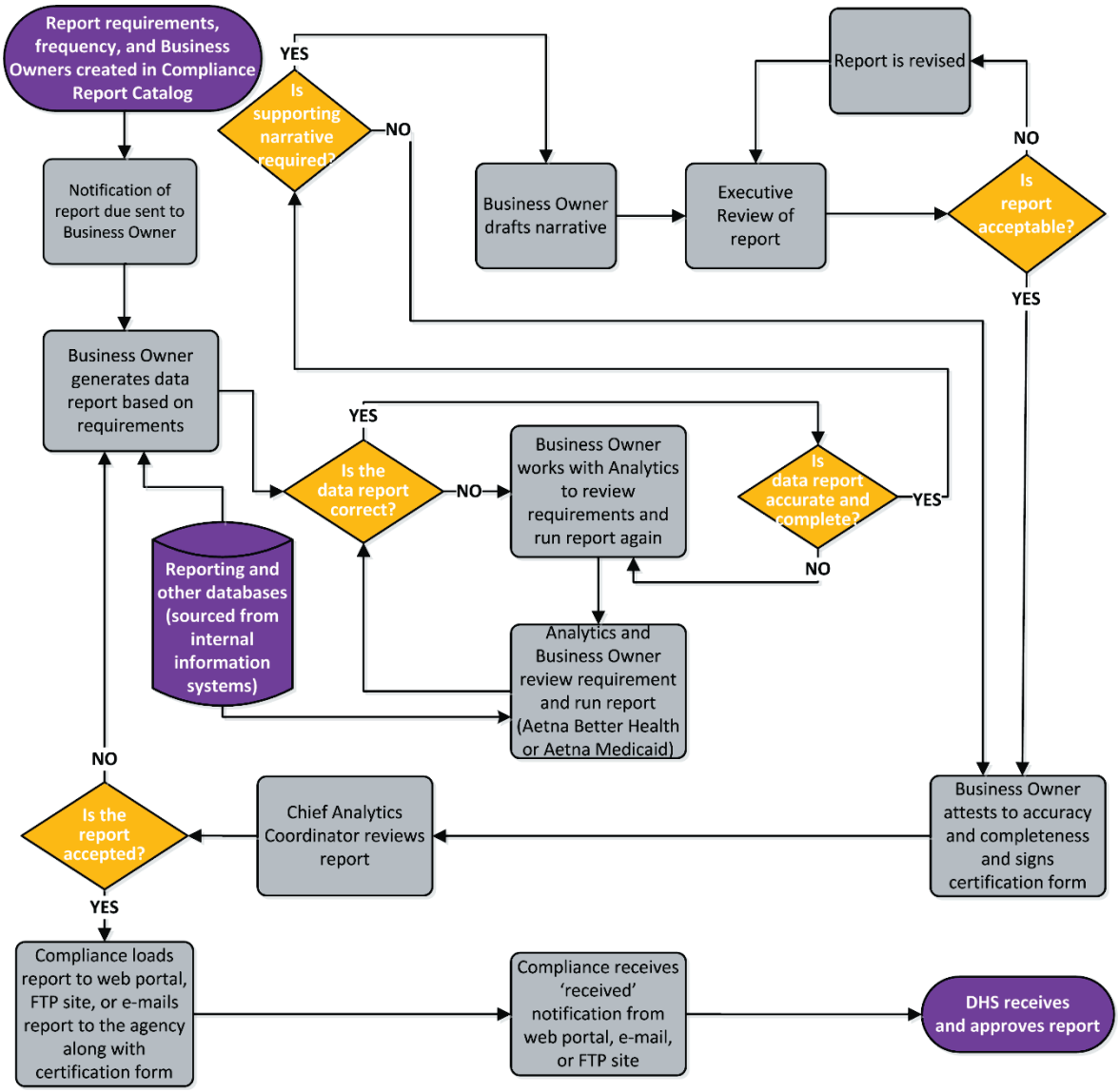
Table 14-1 identifies the primary data sources that we use to generate a broad range of reports.

Table 14-1: Comprehensive data sources

QNXT™	QNXT™ is our business application and data management system and the core of Aetna Medicaid's application architecture. QNXT™ supports business processes and data for: • Claims, including adjudication, payment, coordination of benefits, and third-party liability • Demographic and enrollment, including prior coverage data • Provider contracts, including reimbursement agreements, provider demographics, and contract terms • Prior authorization and special needs • Electronic Data Interchange (EDI) • Maternity care payments • Medicaid eligibility records to support Utilization Management (UM) through prior authorizations and concurrent reviews
Care Management System	Documents Care Plans, inbound and outbound correspondence, physician information, pharmacy utilization, and demographics. Our team uses the application to create Case Management reports.

Figure 14-1 shows our current report generation process.

Figure 14-1: Report generation process



Supporting data quality and transparency

Aetna Better Health uses the Compliance Reporting Catalog to monitor deliverables and promote compliance with required standard reporting deadlines.

The application captures:

- Report name
- Contract citation (if available)
- Report description and criteria
- Report frequency and deliverable dates reminders
- Time period of analysis
- Data sources
- Report owner name, role, and department

Aetna Better Health will call or meet with the Agency as required to discuss report receipt, quality, and compliance. We will also comply with the Agency's rights to audit self-reported data.

Delivering standard reports

As part of the services under our Contract, Aetna Better Health will deliver the following standard reports and performance targets on an agreed schedule:

- Financial
- Member Services
- Provider Network
- Quality Management
- LTSS
- Quality of Life
- Utilization
- Claims
- CMS

FINANCIAL REPORTS AND PERFORMANCE TARGETS

We will meet the performance requirements and submit the following reports:

- Third-Party Liability Collections
- Iowa Insurance Division reporting
- Annual independent audit
- Physician Incentive Plan disclosure
- Insurance Premium Notice
- Reinsurance
- Medical Loss Ratio

MEMBER SERVICES REPORTS AND PERFORMANCE TARGETS

We will meet the performance requirements and submit the following reports:

- Completion of Initial Health Risk Screening
- Completion of Comprehensive Health Risk Assessment
- Care Plan Development
- Member Helpline Performance Report
- Member Enrollment and Disenrollment
- Member Grievances Report
- Member Hearing and Appeals Report
- Summary of CAHPS® (registered trademark of the Agency for Healthcare Research and Quality) Survey
- Member Website Utilization Report
- Member PCP Assignment Report

PROVIDER NETWORK REPORTS AND PERFORMANCE TARGETS

We have developed, enhanced, and will apply our policies, procedures, and processes to monitor our provider, subcontractor, and affiliate networks. Comprehensive reporting and analysis help us provide adequate network capacity, accessibility for our members, and accuracy in our provider listings.

We will meet the performance requirements and submit the following reports:

- Network Geographic Access Reports for Providers
- 24-Hour Availability Audit
- Provider Credentialing Report
- Subcontractor Compliance Summary Report
- Provider Helpline Performance Report

QUALITY MANAGEMENT REPORTS AND PERFORMANCE TARGETS

Aetna Better Health has well-defined processes and procedures throughout our operations to identify and implement targeted improvement activities to address negative trends, access, or quality issues. We

have an established Quality Management (QM) Program to monitor, evaluate, and improve the continuity, coordination, quality, accessibility, availability, and timely utilization of health care and services provided to members. The work plan Outlines QM program deliverables and due dates. The work plan is reviewed quarterly and updates are presented to the QM/UM Committee for approval

The QM Work Plan is a detailed and comprehensive work plan for our clinical and service quality improvement activities, developed by quality leadership and the Quality Assessment & Performance Improvement Committee, and approved by the Board of Directors. The Work Plan provides a formal continuous process by which we will use objective measures to monitor and evaluate the quality of services provided to our members. The QM Work Plan incorporates four complementary work plans that support the overall QM Work Plan:

- HEDIS work plan
- Prevention and Wellness work plan
- Performance Improvement Project work plan
- National Committee for Quality Assurance Accreditation work plan

As part of the overall QM process, Aetna Better Health analytic staff help to establish performance measurement benchmarks and analyze internal and external report data to determine opportunities for improvement. We use industry best practices related to reporting and analytics and frequently monitor and review our processes, tools, and metrics to promote delivery of optimal data analytics to the Agency.

We will provide a Fiscal Year Annual Evaluation to the State and develop a calendar year report. We present the annual evaluation to the Quality Management Oversight Committee (QMOC) and to the Board of Managers. The process includes a focus on health outcomes and action plans for improvement, which we achieve through frequent monitoring of:

- PIPs
- Service monitors
- HEDIS
- Focus studies
- Grievances and appeals
- CAHPS® surveys
- Departmental reports
- Peer-to-peer reviews

And through collaboration with:

- Health Services
- Provider Services
- Community Development
- Member Services
- Compliance

QM Committee Meeting Minutes. Chaired by our Chief Executive Officer, our QMOC monitors and evaluates the operational aspects required for the delivery of high-quality care. The QMOC reviews and approves committee minutes and reports from all committees and subcommittees and submits meeting minutes to the State.

Care Coordination Report. We will generate a set of reports of all members engaged in care coordination programs including summary information on active participation, number of contacts, disenrollment, and outcomes.

HEDIS reporting. We will conduct an annual HEDIS audit survey and submit the compliance auditor's final audit report along with the same audited data provided to NCQA. Aetna Better Health participates in HEDIS to continuously evaluate and improve the health of our members and the quality of care that they receive.

HEDIS results are subjected to a rigorous review by certified HEDIS auditors. Auditors review a sample of all medical record audits performed by us, so we may ask for copies of records for audit purposes. We also monitor the quality and inter-rater reliability of their reviewers to verify the reliability of the information reported.

Quarterly Health Outcomes and Clinical Reports. The Quality Assessment Coordinator and UM Coordinator are responsible for developing, implementing, evaluating, and improving the written quality assessment and improvement program that we complete annually. We will provide a quarterly evaluation report to the Agency, per the Contract.

In our other plans, we present the annual evaluation to the QMOC and to the Board of Directors. The process includes a focus on health outcomes and action plans for improvement. This is achieved through frequent monitoring of PIPs, focus studies, departmental reports, grievances and appeals, peer-to-peer reviews, HEDIS measures, CAHPS® surveys, delegation oversight, and collaboration with Health Services, Provider Relations, Member Services, Compliance, and Community Development.

We will establish quarterly clinical reports and baseline rates to monitor health care services utilization and quality outcomes as required by the Agency, including:

- Behavioral health
- Children's health
- Prenatal and birth outcomes
- Chronic condition management
- Hospitalization and Emergency Department
- Adult preventive care

LTSS reports and performance targets. We currently manage LTSS populations in seven states—Arizona, Florida, Illinois, Michigan, New Jersey, New York, and Ohio—in which we provide LTSS reports as described below.

Our approach will be to identify the challenges early and proactively work to address them by engaging and coordinating with all involved providers and agencies through an integrated care team—the home care service provider, the transportation provider, and any community group that may be a resource to the member. We may work with providers to extend their service hours or ask them if it is possible to expand their service area.

By incorporating these specialized services in member Care Plans, we address each member as a whole person and, with our powerful data and reporting systems, can more easily identify gaps in care and any developing need for additional care.

Nursing Facility Admission Rates. We will provide a Nursing Facility, ICF/ID, and PMIC Admission Rates report to the Agency that will document the nursing facility, ICF/ID, and PMIC admission rates.

Nursing Facility Days of Care. We will provide a Nursing Facility, ICF/ID, and PMIC Days of Care report that will document the number of nursing facility, ICF/ID, and PMIC days used by members.

Return to Community. We will provide a Return-to-Community report that will document the percentage of members who return to the community following nursing facility, ICF/ID, and PMIC admission.

ICF/ID and PMIC Report. We will provide an ICF/ID and PMIC report that will document measures determined by the Agency for ICF/ID and PMIC services.

Fall-risk Management. We will provide a fall-risk management report that documents the percentage of members in long term care who are at-risk for falling who are seen by a practitioner and receive fall-risk intervention.

Hospital Admission after Nursing Facility Discharge. We will provide a hospital-admission-after-nursing-facility discharge report that documents the percentage of members discharged from a nursing facility who subsequently had a hospital admission within 30 days.

Self-Direction. We will provide a self-direction report that documents the number of members who are self-directing eligible Home and Community-based Services (HCBS).

Timeliness of Level of Care. We will provide a timeliness of level of care report that documents our timely completion of level of care reassessments.

Timeliness of Needs Assessment and Reassessments. We will provide a timeliness of needs assessments and reassessments report that documents our timely completion of needs assessments and reassessments for 1915(c) HCBS waiver members. We will complete 100% of needs assessment within the timeframe mutually agreed upon by Aetna Better Health and the Agency in the course of contract negotiations.

Care Plan & Case Notes Audit. We will comply with audits of 1915(c) HCBS waiver Care Plans and case notes to determine Contractor compliance with:

- Timely completion
- Care plan addressing the member's assessed health and safety risks and personal goals
- Member signature on the care plan
- All providers are listed on the care plan
- All funding sources are listed on the care plan
- Plan for supports available to the member if an emergency is documented
- Provision of services as delineated in the care plan
- Discussion of advanced directives with members
- Percentage of new members starting ongoing services within the required timeframe
- Member or guardian participation in care plan development
- Number and percentage of in-person visits that were on time, late, or missed

Critical Incident Reporting. We will provide a critical incident report that documents the number, percentage, and frequency of critical incidents and the number and percentage reported within the required timeframes.

Out-of-State Placements. We will report on members receiving out-of-state placements and providers for adults and children.

QUALITY OF LIFE REPORTS AND PERFORMANCE TARGETS

Achieving higher quality of life is an important goal for our members. To monitor and track improvement, our member assessments and reassessments measure quality of life through the following:

- Initial screen
- Progress screen
- Care management discharge

We will provide a quality-of-life report with areas of measurement that include:

- Increased life expectancy
- Number and percentage of members who gain and maintain competitive employment
- Number and percentage of members engaged in volunteer work
- Satisfaction
- Reduction in homelessness

To support this, at the Agency's request, we will conduct member surveys to measure key experience and quality of life indicators using best practices for reaching populations with special health care needs.

UTILIZATION REPORTS AND PERFORMANCE TARGETS

We will submit required reports and meet performance targets on utilization trends to assess its stability and continued ability to offer health care services to its members.

Program integrity plan. We will update the Program Integrity Plan annually and submit it to the Agency for review. We will also submit to the Agency quarterly high-level progress reports outlining key activities, findings, and progress toward meeting goals and objectives as well as recoupment totals.

Prior authorization report. We will submit a quarterly summary of approvals, pending requests, and denials from the end of the previous reporting period. For services that require prior authorization, we receive requests through our electronic submission system and refer any potential adverse decisions to the Chief Medical Officer or designee for review. Our prior authorization process applies minimal administrative barriers, creating a quick and fair response to providers and members alike.

Pharmacy rebate reporting. We will use an aggressive collection and reconciliation process related to rebate payments. We fully reconcile all payments to the original invoiced amount, then document and escalate any differences to make certain that payment is made on all valid claims submitted to the drug manufacturers. Typically, agreements between the manufacturers and the Pharmacy Benefits Manager include language that provides arbitration to resolving a payment dispute with the contracted manufacturer.

Pharmacy reporting. We will provide additional reporting (as required) specific to the pharmacy program, including:

- Pharmacy help desk performance
- Prior authorization performance
- Prior authorization request turnaround time
- Number of claims submitted as a 72-hour emergency supply
- Denials (name of drug, number of requests, number of denials)
- Pharmacy network access
- Grievance and appeals and medication therapy management initiatives

CLAIMS REPORTS AND PERFORMANCE TARGETS

We will submit required claims processing and adjudication data. We also identify specific cases and trends to prevent and respond to any potential problems relating to timely and appropriate claims processing. We will meet the State's prompt payment requirements and report the top ten reasons for claims denials to the Agency.

CMS REPORTING

We will submit CMS-required reporting data for Iowa Health and Wellness Plan and HCBS Waiver members in the manner and timeframe required, including:

- The number of individuals subject to premium requirements
- The number of individuals whose premiums have been waived due to compliance with healthy behaviors
- The number of individuals exempt due to hardship
- The number of individuals with overdue premiums including those with premiums past due less than and greater than 90 days
- Information about the State's collection activities
- The number of individuals who have premiums that have become collectible debt

IDPH REPORTING

We will submit reports to IDPH as necessary to support the Substance Use Disorders Prevention and Treatment Block Grant and other reporting requirements as determined by IDPH.

Attachment 5 – Section 14, Question 2

Describe additional data/reports you are capable of providing that can help the State evaluate the success of the program.

Custom reporting

Our Informatics Team is well versed in creating custom reports to support emerging initiatives in the 17 states we serve or to focus on specific areas of performance.

For example, if the Agency would like to take a closer look at provider networks and performance, we could develop a custom report from an array of data such as after-hours access by provider type; PCP-to-member ratios by provider type, capacity or referral limits, grievance data, secret shopper survey data, changes in open/closed panels, and more. Our Informatics staff can work with business owners and our Compliance Officer to create the report scope.

Our New Jersey health plan developed a custom LTSS Triage Report that provides a weekly dashboard of high-level claims, care management, and member services activity to help identify potential hotspots (Figure 14-2). This kind of weekly reporting may be particularly effective during implementation to help spot and address potential issues—typically through targeted provider education and outreach—before they become too complex to correct or reverse.

Figure 14-2: [redacted] **CONFIDENTIAL**

[redacted]

As another example, our Nebraska health plan requested a custom UM Report to track key metrics on member counts, inpatient admissions, and claims services (Figure 14-3).

Figure 14-3: [redacted] – CONFIDENTIAL

[redacted]

Attachment 5 – Section 14, Question 3

Describe your internal operational structure that will support the compilation of the performance data and reporting processes of the programs, including:

Operational structure, responsibility, and oversight

Upon Contract award, Aetna Better Health's Informatics Analyst will conduct a thorough review of the reports the Agency requires and verify results in the Compliance Report Catalog. The Informatics Analyst will confirm that reports meet all Contract requirements and the Agency's quality and content expectations. This includes:

- Adhering to defined standards, templates, formats, and submission requirements
- Revising and resubmitting previously submitted reports within timeframes and formats that the Agency requests
- Changing report production schedules as requested (either more or less frequently than originally agreed during implementation)
- Submitting reports accurately and on time
- Certifying all reports for accuracy, completeness, and truthfulness prior to submission
- Notifying the Aetna Better Health Compliance Officer of report status

Quality data and expert analysis through an experienced team

We have an experienced team dedicated to data analytics and tactical business tool development. We will add analytical resources to support delivering the increased volume of required reports and to assist with quality assurance, certification, and submission. We will continue to regularly monitor performance to determine the resources needed to meet the Agency's requirements in the most efficient manner.

Provider Services, Quality Improvement, and the LTSS Departments have resources to support business area–specific data and analysis needs. These resources will carry over to the new Contract. The Enrollment Department also has several data and analysis staff who support reporting needs. These departments maintain business processes and monitoring policies and procedures that enable them to develop and deliver accurate, compliant, and timely reports.

In summary, we will use a blend of the following resources as appropriate to support our commitment to meeting report requirements in the new Contract: Data analytical staff; Business Analysts; Compliance; and the Aetna Medicaid Informatics, Finance, Medical Economics, Actuarial Services, and Information Technology staff.

AETNA MEDICAID REPORTING RESOURCE

In delivering services under the Contract, Aetna Better Health will continue to contract with an affiliate, Aetna Medicaid Administrators, LLC (Aetna Medicaid) for a broad array of management and administrative services. We will also continue to receive certain limited administrative services from its affiliate Aetna Health Management, LLC (AHM) through a subcontract between AHM and Aetna Medicaid as well as certain limited services from its affiliate Aetna Life Insurance Company (ALIC) which is a subcontractor of AHM. Unless specifically stated otherwise, reference within this response to Aetna Medicaid will refer collectively to Aetna Medicaid and its affiliate subcontractors AHM and ALIC.

Although Aetna Better Health is responsible for reporting to the Agency, we have the support of the Aetna Medicaid Informatics Reporting and Data Analytics Team as needed. The team focuses on three key information support initiatives:

- Custom reports and analytics
- HEDIS® (registered trademark of NCQA)
- Data extraction and integration

We structured our Aetna Medicaid Informatics Reporting and Data Analytics Team to maximize reporting efficiency and accuracy while taking into account reporting and information requests by type. The team will produce a wide variety of standard and ad hoc reports to support Aetna Better Health and provide information and analytics support to our Medical Management team and operating areas.

Aetna Medicaid reporting and data analytics support

The Aetna Medicaid Informatics Reporting and Data Analytics Team follows a systematic approach to completing data requests when called upon for support. This approach enables timely capture, completion, and release of all deliverables. The Informatics Reporting and Data Analytics Team oversees current work and confirms that quality checks and verifications are handled appropriately. A Project Manager reviews each request with the Aetna Better Health requestor to define and document the reporting requirements. Once the Aetna Better Health requestor approves the reporting requirements, the request is assigned to a member of the Informatics Reporting and Data Analytics Team to develop the solution. The assigned Analyst, peers as appropriate, and the Aetna Better Health requestor test the solution, evaluating data integrity and other considerations. The Analyst addresses any accuracy concerns raised during testing, and the resulting solution is re-tested.

The Informatics Reporting and Data Analytics Team tracks all requests, analyzing the initial estimate of the size and scope of the request as it compares to the actual size and scope; the expected time to complete the request versus actual time to complete the request; and the expected delivery date versus actual delivery date. Upon completion of the project, the team solicits feedback from the Aetna Better

Health requestor to assess satisfaction levels related to specific requests and to gather suggestions for improvement. The Informatics Reporting and Data Analytics Team regularly reviews this information to target areas for improvement.

Attachment 5 – Section 14, Question 3.a

The qualifications and experience of the staff responsible for the production and delivery of performance data to the State.

KEY ROLE: THE INFORMATICS ANALYST

The Informatics Analyst is responsible for aggregating clinical and financial health care data from multiple sources to generate integrated analytic reports and datasets that support Agency performance monitoring and emerging initiatives. The Informatics Analyst designs and codes using SAS/SQL and produces results such as lists, reports, graphical summaries, statistics, and statistical analyses. Day-to-day activities include programming, data management, data acquisition, and documentation.

The Informatics Analyst serves as a problem-solver who collaborates with the full range of services across Aetna Better Health, including Actuarial Services, Compliance, Enrollment, Finance, Information Technology, LTSS, Medical Economics, Member Services, Provider Services, and Quality Improvement.

The Aetna Medicaid Informatics Team creates value by expanding the range of actionable information for the states we serve through both standard and highly customized reporting.

The Informatics Team executes complex data queries, integrates health care data from multiple sources, and applies appropriate research and statistical methods to help internal and external decision-makers assess health and economic outcomes, including utilization measures and quality and cost data.

We require the Informatics Analyst to be conversant in multiple reporting platforms and to have an understanding of relational databases, data systems, and data warehouses. The Informatics Analyst must have a Bachelor's degree in Mathematics, Economics, Statistics, Computer Science, Actuarial Science, Social Science, or Health Care, and one or more years of programming or data analysis experience, with knowledge of health care or pharmaceutical industry preferred.

Attachment 5 – Section 14, Question 3.b

The process for internal review and validation of data prior to submission to the State.

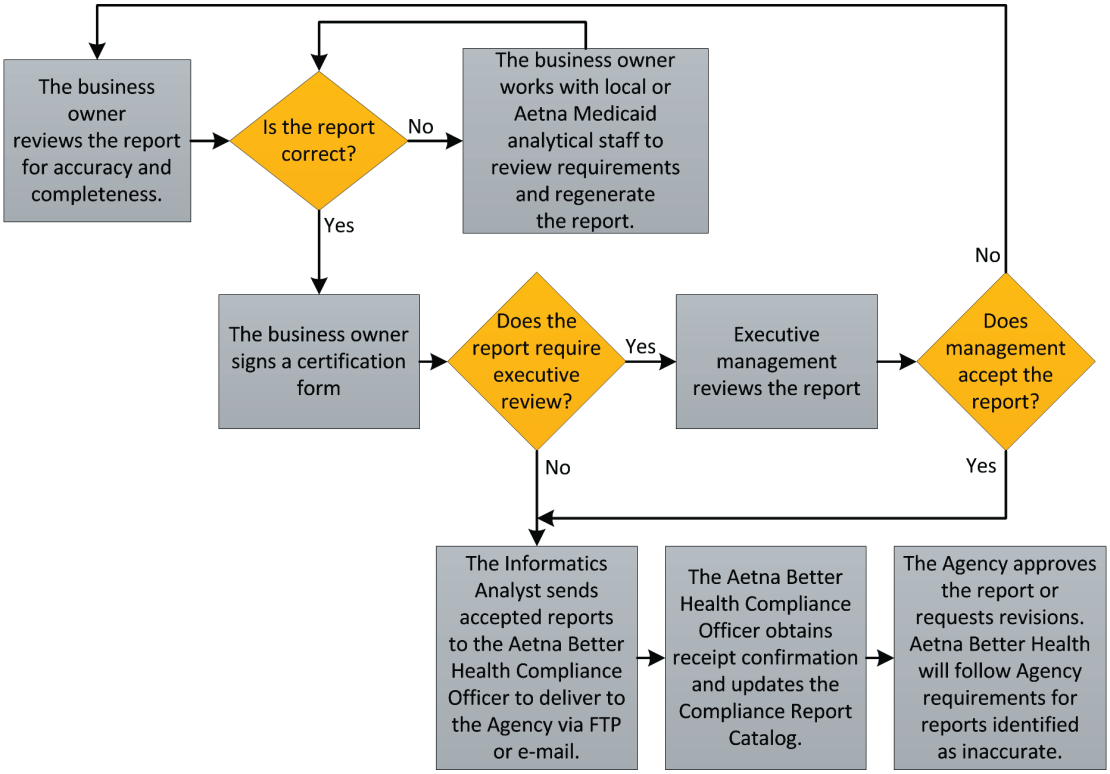
INTERNAL REVIEW AND DATA VALIDATION

Under the Contract, our Informatics Analyst will oversee and monitor use of the Compliance Reporting Catalog and work in conjunction with the Aetna Better Health Compliance Officer to facilitate the consistent and timely delivery of all standard requested reports to the Agency. Business owners for each report deliverable will be responsible for updating and validating the data in the catalog.

If business requirements change or the data within the reports are questioned, the report owner will review the change requests or issues with the business owner or project leader, discuss the inaccuracy, and determine the proper solution. Aetna Better Health will proactively notify the Agency of any discrepancies we find during internal review. We will take corrective actions to confirm that we document and correct any identified discrepancies a within State-required timeframes.

By validating data, we establish an additional level of accuracy and oversight in the reports we deliver to the Agency. Figure 14-4 details the steps of our validation process.

Figure 14-4: Our data validation process requires multiple steps of review and signoff



Attachment 5 – Section 14, Question 4

Please provide any available Medicaid HEDIS scores in states in which you operate.

Recent HEDIS scores

Aetna Better Health is backed by the established HEDIS® (registered trademark of NCQA)-reporting capabilities and related Quality Improvement programs and expertise of our affiliate and subcontractor, Aetna Medicaid. In Appendix V, we include recent HEDIS scores from Medicaid and the Children's Health Insurance Program supported by our health plans that Aetna owns, operates, or administers in:

- Arizona
- Delaware
- Illinois
- Florida
- Kentucky
- Maryland
- Michigan
- Missouri
- Nebraska
- New York
- Pennsylvania
- Texas
- Virginia
- West Virginia

These scores represent measurement year 2013, the most recent scores available. Our New Jersey, Ohio, and Louisiana health plans do not yet have HEDIS data as these are new programs and results are not yet available.

As quality-driven, results-based organizations, our health plans regularly monitor HEDIS results as part of their Quality Assurance and Performance Improvement programs. When results do not meet performance goals or benchmarks, the health plans identify barriers to improvement and implement Quality Improvement initiatives to improve performance and member health status.

Attachment 5 – Section 14, Question 5

Provide a copy of your most recent external quality review report for the Medicaid contract that had the largest number of members as of the RFP release date.

External Quality Review report

Aetna Medicaid health plans participate in the external quality review organization (EQRO) process. As Appendix T, we submit the most recent available external quality review report dated March 2014 for Kentucky, our Aetna Medicaid health plan with the largest Medicaid enrollment. The report covers the review period from January 1, 2013, through December 31, 2013.

The criteria for external quality review scoring includes:

- Quality Assessment and Performance Improvement
- Grievance System
- Health Risk Assessment
- Structure and Operations Credentialing
- Access
- UM
- Program Integrity
- EPSDT
- Delegation
- Health Information Systems
- Case Management and Care Coordination
- Member Rights
- Medical Records
- Behavioral Health Services

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Section 15: Termination

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SECTION 15 – TERMINATION

The table below outlines how the Scope of Work provided in RFP Attachment 1 relates to the responses to the questions provided in RFP Attachment 5. We provide this table to reduce redundancy of responses and information and to simplify the evaluation process for the evaluators.

For requirements in Attachment 1 that do not require a detailed response, the table below indicates our intent to comply with the stated requirement in lieu of repeating the RFP question and including a will comply statement within the body of the narrative.

Attachment 1 Requirement	Cross Reference to Attachment 5	Will Comply
15.1 Contractor's Termination Duties	--	Yes
15.1.1 Duties	Section 15, Question 1	Yes
15.1.1.1	Section 15, Question 1	Yes
15.1.1.2	Section 15, Question 1	Yes
15.1.1.3	Section 15, Question 1	Yes
15.1.1.4	Section 15, Question 1	Yes
15.1.1.5	Section 15, Question 1	Yes
15.1.1.6	Section 15, Question 1	Yes
15.1.1.7	Section 15, Question 1	Yes
15.1.1.8	Section 15, Question 1	Yes
15.1.1.9	Section 15, Question 1	Yes
15.1.1.10	Section 15, Question 1	Yes
15.1.1.11	Section 15, Question 1	Yes
15.1.1.12	Section 15, Question 1	Yes
15.1.1.13	Section 15, Question 1	Yes
15.1.1.14	Section 15, Question 1	Yes
15.1.1.15	Section 15, Question 1	Yes
15.1.1.16	Section 15, Question 1	Yes
15.1.1.17	Section 15, Question 1	Yes
15.1.1.18	Section 15, Question 1	Yes
15.1.1.20	Section 15, Question 1	Yes
15.1.1.21	Section 15, Question 1	Yes
15.1.1.22	Section 15, Question 1	Yes
15.1.1.23	Section 15, Question 1	Yes

15. Termination

Please explain how you propose to execute Section 15 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

In this section, we address termination by:

- Agreeing to meet all requirements
- Describing our relevant experience in contract transitions
- Providing a sample transition plan in Table 15-1 "Sample end-of-contract transition plan" in response to Question 2 in this Section

No terminations for non-performance

Aetna Better Health of Iowa Inc. (Aetna Better Health), as a new entity and has never had any Medicaid managed care contract terminated, or not renewed for non-performance, poor performance, or non-compliance.

Aetna Health Holdings, LLC is Aetna Better Health's parent company. Aetna Health Holdings has never had any Medicaid managed care contract terminated or not renewed for non-performance, poor performance, or non-compliance.

Aetna Inc. is Aetna Better Health's ultimate corporate parent. Aetna Inc. has never had any Medicaid managed care contract terminated or not renewed for non-performance, poor performance, or non-compliance.

Furthermore, we are not aware of any terminations or non-renewal of any publicly funded managed care contracts that were caused by the Aetna organization's non-performance, poor performance, or non-compliance.

For details on our Termination, Litigation, and Investigation information for the past five years, please see our response to **RFP Section 3.2.5.4 in Tab 4**.

Contract termination and Exhibit E: Sample Contract Section 2.5

As indicated in RFP Exhibit E: Sample Contract Section 2.5 Termination, we understand that the Agency reserves the right to terminate the Contract, in whole or in part, due to the failure of the Contractor to comply with any term or condition of the Contract, or failure to take corrective action as required by the Agency to comply with the terms of this Contract.

Collaborating with other states to manage member transitions

Our health plans have worked closely with other state agencies to manage the smooth transition of members following the termination of state contracts for reasons other than non-compliance. We will leverage the experiences of our health plans to manage any transition required for our Contract with the Agency.

When Aetna acquired Coventry we both had plans in the state of Missouri due to which resulted in the company owning 2 of 3 health plans in the State with almost 90% of the members. In order for the State to approve the transaction, we needed to divest one of the plans. We sold the plan, Aetna worked closely with the State and the new plan, members and providers to provide seamless continuity of care including care management and transition.

Attachment 5 – Section 15, Question 1 [SOW 15.1.1]

Describe your plan to complete the duties outlined in Section 15 in the event of contract termination or expiration.

Plan to complete duties in the event of contract termination or expiration

Our sample Transition Plan, included as Table 15-1 in response to Question 2 in this Section, summarizes our plan to complete the duties outlined in Section 15 if the Agency were to terminate the Contract or it expired. Upon receipt of notice of termination or request of the Agency, we will complete the deliverables listed to minimize the disruption of services to members and providers to include the following:

- Cooperating in good faith with the Agency during the transition period
- Appointing a liaison for post-transition concerns and providing for sufficient Claims Payment, Member Services, Care Coordination, and Provider staff
- Providing a written transition plan to be approved by the Agency
- Providing the Agency requested records in the format and timeframes required by them
- Providing the Agency performance data including CAHPS® (registered trademark of the Agency for Healthcare Research and Quality) and HEDIS® (registered trademark of NCQA)
- Participating in the external quality review for the final year of the Contract
- Maintaining financial requirements as described in the Contract
- Submitting reports to the Agency every 30 calendar days, detailing our progress in completing our contract obligations
- Resolving member grievances
- Maintaining claims processing functions
- Being financially responsible for
  - All claims with dates of service through the day of termination
  - Services rendered through the day of termination
  - Inpatient services through the day of discharge
- Submitting encounter data to the Agency for claims

- Arranging for orderly transfer of patient care and records
- Within the bounds of federal and state laws related to the privacy and protection of member data, including but not limited to HIPAA, we will work cooperatively with and supply program information to any successor program contractors.
- Notifying all providers about the Contract termination
- Reporting any capitation or other overpayments made
- Taking all actions necessary to make certain the efficient and orderly transition of members from coverage under this Contract to coverage under any new arrangement developed by the Agency

Payment obligations

We understand that:

- Termination or expiration of the Contract does not discharge our obligations with respect to services or items furnished before termination or expiration of the Contract.
- Termination or expiration of the Contract does not discharge the Agency's payment obligations to us or our payment obligations to our subcontractors and providers.

Continuation of services for members if the Contract is terminated

We confirm that if our Contract is terminated, the Agency reserves the right to require us to continue to serve or arrange for provision of services for members for up to 45 calendar days from the Contract termination date or until the members can be transferred to another program contractor, whichever is longer. During this transition period, the Agency will continue to make payments under the terms of the Contract.

Agency's right to withhold payments

We understand that the Agency reserves the right to withhold some or all retroactive capitation adjustment payments if we fail to comply with the responsibilities set forth in this section.

Providing performance data following Contract termination

We will provide the Agency or their designated entity (not the successor program contractor) all performance data with a due date following the termination or expiration of the Contract. This performance data will cover a reporting period before termination or expiration of the Contract, including but not limited to CAHPS® and HEDIS.

Health and Wellness Plan member information

We will provide the Agency, in the format and within the timeframes set forth by the State, information on all Iowa Health and Wellness Plan members' completion of Healthy Behaviors Program requirements as agreed upon during contract implementation.

Attachment 5 – Section 15, Question 2 [SOW 15.1.1]

Provide a general end-of-contract transition plan which addresses the key components outlined in Section 15.

General end-of-contract transition plan

As requested in Scope of Work (SOW) requirement 15.1.1.4, we will submit a written transition plan to the Agency for approval within 60 days of Contract execution. We will work with the Agency to revise the plan as necessary in order to obtain approval.

In the event of Contract expiration, termination, or cancellation, we will develop and present to the Agency for approval a comprehensive transition plan that meets all Contract requirements and the needs and expectations of our members, our providers, and their communities. The plan will include:

- Provisions for meeting all requirements within the Agency's prescribed timelines for curing a breach of Contract
- Returning overpayments
- Continuation of services
- Completing the transition period, as applicable

Our plan will meet all requirements described in the RFP and will include procedures to keep the Agency fully informed throughout the transition process.

Table 15-1 outlines our **sample general end-of-contract transition plan**. It includes detailed action points for major functions to meet all stakeholder needs and expectations for care and service continuity in order to minimize the disruption of services to members and providers.

Table 15-1 - Sample end-of-contract transition plan

#	Function	End-of-contract transition action plan objective	Timeframe
1	**Medical Management**	Coordinate the transition of: • Behavioral Health • Emergency Services • EPSDT Services • LTSS • Chronic Condition Health Homes • 1915(i) Habilitation Services and 1915(c) Children's Mental Health (CMH) Services • Iowa Health and Wellness Plan • Value-Added Services	To be negotiated with the Agency
2	**Transition of care**	• Maintain staffing and processes focused on continuity of care for all members, and especially for members in case management	To be negotiated with the Agency
3	**Utilization Management (UM)**	• Process prior authorizations through termination date -option to authorize service with Date of Service (DOS) post-termination • Provide census of individuals who are inpatient as of termination date • Manage inpatient admittances until discharge • Transition authorizations (option of open and closed authorizations) to the Agency via standard file transfer process • Identify and transfer agreed upon UM information	To be negotiated with the Agency

#	Function	End-of-contract transition action plan objective	Timeframe
4	**Care Coordination**	• Manage care coordination cases until termination date • For those members in a course of treatment for which a change of providers could be harmful, we will continue to provide services until that treatment is concluded, or appropriate transfer of care can be arranged • Identify and transfer agreed upon care coordination information	Until termination date or until treatment is concluded or appropriate transfer of care can be arranged
5	**Quality Management**	• Identify and support needed HEDIS activities post-termination • Participate in the External Quality Review, as required by 42 CFR 438, Subpart E, for the final year of the Contract	To be negotiated with the Agency; for final year of contract
6	**Grievances and Appeals**	• Process appeals and grievances through agreed upon run-out period	Through agreed upon run-out period
7	**Pharmacy**	• Process Rx prior authorizations through termination date • Process Rx claims through agreed upon run-out period	To be negotiated with the Agency
8	**Determine what information the Agency will need**	Information the Agency will need may include the following: • Open or closed authorization files • Encounter files • Members in care management • Information on identified high-risk members • Performance 15 data • Healthy Behaviors Program data	To be negotiated with the Agency
9	**Provider and Member Communications**	• Establish, implement, and monitor provider and member communications plans, including specific instructions for provider claim submission and member and provider inquiries • Provider notification letter – send Agency-approved Provider Communication Letter	To be negotiated with the Agency
10	**Network Management**	• Notify delegated entities of contract termination • Maintain network of credentialed providers through termination date	To be negotiated with the Agency

11	**Member and Provider Service**	• Make reasonable effort for call center processes and infrastructure support to meet fluctuating needs
		• Create and use Agency-approved call script for members
		• Create and use Agency-approved call script for providers
		• Take inbound calls from members, providers, and UM until termination date
		  ◦ Maintain number for providers during agreed upon claims run-out period
		  ◦ Discuss options for automated response on member call line or short extension of call line post-termination
			To be negotiated with the Agency

12	**Marketing**	• Cancel any open orders for marketing materials • Maintain services and support throughout transition period for ID cards, enrollment kits, and member materials	To be negotiated with the Agency
13	**Enrollment**	• Establish agreed upon shut-off date for member enrollment in health plan • Process enrollment file and exceptions through termination date • Apply termination date for all members in claims system • Determine last date for processing ID cards and welcome packets	To be negotiated with the Agency

#	Function	End-of-contract transition action plan objective	Timeframe
14	**Claims and Finance**	• Through the agreed upon run-out period of a minimum of 12 months: ◦ Manage claim adjudication and payment ◦ Manage payments to any vendors ◦ Continue to provide needed claims data and reporting ◦ Continue to provide needed provider data and reporting • Research and resolve claims issues • Complete or close pending claims projects • Capitation Reconciliation • Maintain medical claims inventory and turnaround time at optimal levels through the transition and run-out period • Maintain provider web portal access for claims look-up through claims run out	Through agreed upon run-out period of a minimum of 12 months
15	**Financial Requirements**	• Maintain the financial requirements, as described in the Contract as of the date of termination notice, fidelity bonds and insurance set forth in the Contract until the Agency provides us written notice that all continuing obligations of the Contract have been fulfilled	Until the Agency provides written notice that all continuing obligations of the Contract have been fulfilled
16	**Subrogation or Third party liability (TPL) file management**	• Establish and implement procedures and accountabilities for submitting TPL data through agreed upon run-out period • Maintain services and support throughout agreed upon run-out period to optimize savings and recoveries	To be negotiated with the Agency
17	**834/820 file transfer**	• Establish accountabilities and schedules for file transfers through transition or run-out period	To be negotiated with the Agency
18	**Encounters**	• Establish and implement procedures and accountabilities for processing encounters and submitting encounter data through transition or run-out period of at least 15 months • Resolve encounter file errors • Coordinate vendor encounter file submissions	Through transition or run-out period of at least 15 months after termination or expiration of the Contract
19	**Special Investigations Unit (SIU)**	• Continue SIU functions through termination date and as applicable through agreed upon run-out period • Establish case or information sharing and transfer protocols	To be negotiated with the Agency
20	**Compliance**	• Complete contract deliverables by termination date and identify any deliverable to continue during agreed upon run-out period	To be negotiated with the Agency
21	**Subcontractor or vendor relations**	• Establish and implement procedures and accountabilities for managing subcontractor service run-out and contract termination • Notify subcontractors of plan closure • Review related contracts for closure activities	To be negotiated with the Agency
22	**Information Technology and Informatics and Reporting**	• Support required report processing and generation through termination date and agreed upon run-out period • Confirm Secure File Transfer Protocol will continue • Support required data submissions to the Agency through termination date and agreed upon run-out period	To be negotiated with the Agency

#	Function	End-of-contract transition action plan objective	Timeframe
23	**Records retention**	• Establish and implement procedures and accountabilities for communicating and meeting regulatory requirements for preserving and making available books, papers, records, and other evidence involving transactions related to the terminating contract • Provide to the Agency all requested records related to activities undertaken pursuant to the Contract, in the format and within the timeframes set forth by the State	To be negotiated with the Agency No later than 30 calendar days of the request
24	**Website**	• Update website to address health plan termination and any required messaging • Maintain provider portal access for claim inquiry	To be negotiated with the Agency
25	**Reporting**	• Submit progress reports to the Agency every 30 calendar days • Continue to meet all State agency reporting requirements, including HEDIS data • Determine required reports during agreed upon run-out period	To be negotiated with the Agency
26	**Human Resources**	• Appoint a liaison for post-transition concerns and provide for sufficient claims payment staff, member services staff, care coordination staff and provider services staff to promote a smooth transition	To be negotiated with the Agency
27	**Facilities**	• Manage infrastructure to maintain service levels throughout transition	To be negotiated with the Agency
28	**Transition meetings and updates**	• Schedule regular internal transition meetings and meetings with the Agency • Provide transition/termination updates in an agreed upon format and timeframe	To be negotiated with the Agency

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AB 4: BIDDER'S BACKGROUND

AETNA BETTER HEALTH® OF IOWA

Tab 4: Bidder's Background

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3.2.5.1 Experience

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3.2.5.1 EXPERIENCE

3.2.5.1.1 Technical experience

Level of technical experience in providing the types of services sought by the RFP.

Continuing our commitment to Iowa

Stability, Competency, and Trust in the Face of Challenge

Our parent organization has been operating in Iowa since 1985, and our affiliate health plan in Iowa, Coventry Health Care of Iowa (CHC), currently serves over 178,000 members including over 10,000 members that are Medicaid eligible. CHC is the **sole remaining plan participating in the Iowa Health and Wellness Plan** created by Governor Branstad's vision to innovate and develop next-generation health care payment and delivery models. Our existing commercial and Medicare network has 20,304 physicians (Primary Care Providers and specialists), and over 4,000 facilities (hospitals, ambulatory surgical centers, skilled nursing facilities, radiology centers, etc.). We are not new to Iowa; rather, we have institutional knowledge about Iowa that we will leverage as we create our provider network for the State. Because of Aetna Medicaid's decades of experience in contracting provider networks in rural areas, we understand the access challenges facing Iowa.

The Aetna Medicaid Mission

Aetna's purpose is empowering people to live healthier lives. We achieve this by embedding our Company values of Integrity, Excellence, Caring, and Inspiration into our culture and all that we do. At Aetna Medicaid, we believe in improving every life we touch as good stewards to those we serve, with Aetna's purpose and values as our foundation.

Aetna Better Health brings the capability—the people, processes, technology infrastructure, and demonstrated resources—to deliver and implement the full scope of covered benefits for Iowa members. We support the Iowa High Quality Healthcare Initiative (the Initiatives) as the next step in the evolution of the Governor's vision to reform Medicaid and define the next generation of effective health care coverage and service delivery. **We will preserve the legacy of service and commitment established by CHC by continuing to serve Iowans.**

Vast experience serving those most vulnerable

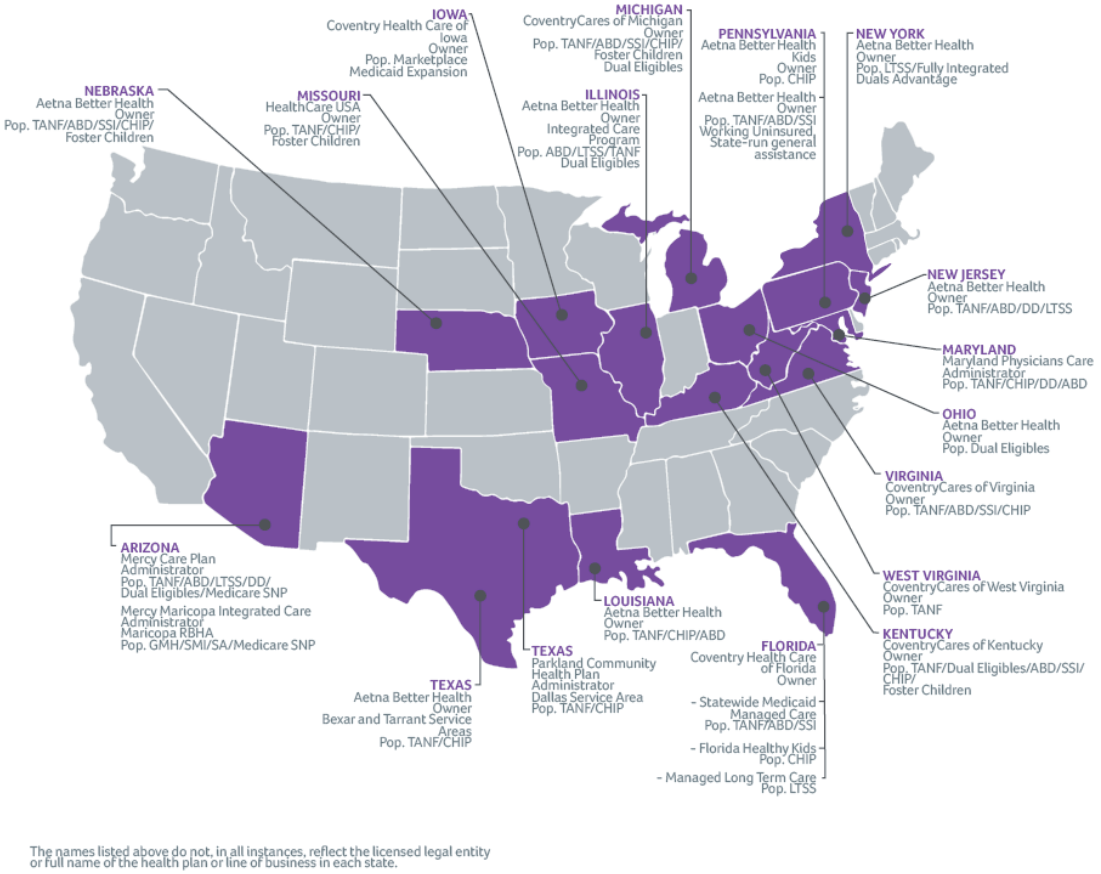
Three Decades of Caring for Those Most Vulnerable

We will leverage the vast experience of Aetna Medicaid (*Aetna Medicaid is comprised of Aetna Medicaid Administrators LLC, along with its affiliates that support the organization's Medicaid operations*), which has close to 4,000 employees and demonstrated experience, resources, and infrastructure to support Aetna Better Health in implementing and conducting its Medicaid business in Iowa. Aetna Medicaid has been a **leader in Medicaid managed care since 1986 and currently serves nearly 3 million members in 17 states including integrated dual eligible demonstrations in five markets: Arizona, Illinois, Michigan, Ohio and New York.**

We will exemplify the integrity that Aetna Medicaid has exhibited over the past 30 years across our nation, as recently demonstrated by our Delaware plan. We will also leverage the depth of resources and infrastructure of parent company, Aetna Inc.

Established in 1853, Aetna has more than 160 years of experience serving approximately 37.3 million members. The map that follows as Figure T4-1 illustrates our national footprint and the knowledge base that will be available to support Iowa.

Figure T4-1: Aetna Medicaid map



Aetna Medicaid has nearly 30 years of experience in managing the care of the most vulnerable, using innovative approaches to achieve successful health care results and favorable cost outcomes. Aetna Medicaid has particular expertise serving high-need Medicaid members, including over 190,000 ABD members; over 37,000 in integrated dual eligible programs and nearly 11,000 duals where we cover only the Medicaid benefit; nearly 25,000 in specific LTSS programs; over 801,000 SMI members; and over 10,000 members in I/DD or DD programs. Our experiences, and the services we offer, are consistent with the scope of services the Iowa Department of Human Services (the Agency) is asking us to perform.

Aetna Medicaid administers or provides administrative support to managed care programs for Medicaid and Children's Health Insurance Program (CHIP)-eligible populations, including:

- Children
- Pregnant women
- Childless adults
- Seniors and individuals with adult onset disabilities
- Individuals with severe and persistent disabilities
- Individuals with developmental disabilities

- Individuals requiring Long Term Services and Supports (LTSS)
- Individuals with a special health care needs
- Individuals with behavioral health needs
- Individuals who are dually eligible for Medicare and Medicaid benefits

Table T4-1, below, further details our nation-wide experience providing the types of services sought by the RFP.

Table T4-1: Aetna Medicaid Nationwide experience providing the services sought in this RFP

	States where we have this experience															
Service Offered	**AZ**	**FL**	**IL**	**KY**	**LA**	**MD**	**MI**	**MO**	**NE**	**NJ**	**NY**	**OH**	**PA**	**TX**	**VA**	**WV**
Adaptive aids	✓				✓		✓				✓	✓				
Administration of Covered Benefits	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Advance Directives	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ambulance services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Audiology services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Behavioral Health services	✓	✓	✓		✓		✓			✓	✓	✓	✓	✓	✓	
Prenatal care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Birthing services (by a physician or CNM)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Birthing services (by a licensed birthing center)	✓	✓				✓		✓				✓	✓	✓	✓	✓
Business Continuity and Disaster Recovery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cancer screening, diagnostic, and treatment service	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chiropractic services	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health Homes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Claims Reports	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Continuity of Care Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Community Based Case Management Monitoring										✓	✓					
Dialysis	✓	✓	✓		✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
Drugs and biologicals in an inpatient setting	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Durable medical equipment and supplies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Service Offered	States where we have this experience															
Electronic communications to members	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Electronic communications to providers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Emergency services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Employment assistance	✓															
Enrollment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Family planning services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Federally Qualified Health Centers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Coordination of Financial Management Services with the Agency	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Financial Reports	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Flexible Family Support Services	✓	✓	✓							✓	✓					
Fraud, Waste, and Abuse Prevention	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Grievances, Appeals, and State Fair Hearings	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HIPAA Compliance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health education and initiatives	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Home health care services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hospital services, inpatient and outpatient	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Provider Incentive Programs	✓		✓			✓	✓		✓				✓	✓		
Indian Healthcare Providers	✓								✓							
Integrated Care (to include Physical and Behavioral Health)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Implementation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Laboratory	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Long Term Services and Supports (LTSS)	✓	✓	✓							✓	✓					

Service Offered	States where we have this experience															
LTSS Reports	✓	✓	✓							✓	✓					
Mastectomy and related follow-up	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maternal and Child Health Centers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Therapies – physical, occupational, and speech	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medical checkups and comprehensive care program services through EPSDT	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Coordination with Medicare	✓		✓	✓			✓				✓	✓				
Mental health rehabilitation	✓	✓	✓								✓	✓	✓	✓	✓	
Member Services Helpline	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Member Services Reports	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Member Website	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mental health targeted case management	✓	✓	✓		✓		✓			✓	✓	✓	✓	✓		
Minor home modifications	✓	✓					✓			✓	✓	✓				
Nurse Call Line	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	✓
Nursing Facilities	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Oral evaluation and fluoride varnish	✓	✓	✓	✓	✓		✓	✓		✓	✓	✓	✓	✓		✓
Outpatient drugs and biologicals	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Personal Care Services	✓	✓	✓				✓			✓	✓	✓		✓		
Pharmacy Services	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Podiatry	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Program Integrity Planning	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Provider Network Development and Maintenance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prescribed pediatric extended care services					✓									✓		
Primary care services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Service Offered	States where we have this experience															
Private Duty Nursing services	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓			✓	✓
Provider Network Reports	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality Management and Improvement	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality of Life Reports	✓	✓	✓							✓	✓					
Radiology, imaging, and X-rays	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Redetermination Assistance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Residential Services	✓	✓	✓	✓			✓			✓	✓	✓				
Respite care	✓	✓	✓	✓			✓			✓	✓	✓	✓			
Rural Health Clinics					✓		✓	✓	✓			✓	✓	✓	✓	✓
Coordination with Safety Net Providers and Community Providers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Specialty physician services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Stakeholder Education	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Substance Use Disorders Services (including those court ordered)	✓	✓	✓				✓			✓	✓	✓	✓	✓		
Supportive employment for LTSS population	✓		✓													
Telemonitoring	✓						✓		✓	✓		✓				
Telehealth	✓				✓		✓		✓	✓		✓				
Member Incentive Programs		✓			✓			✓					✓	✓		
Third Party Liability Processing	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Transition assistance services for LTSS population	✓	✓	✓							✓	✓					
Transitions between facilities	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Transplantation of organs and tissues	✓		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
Urgent Care Clinics	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Utilization Management	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Service Offered	States where we have this experience															
Vision services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
1915(i) Habilitation Program Services			✓								✓	✓	✓	✓	✓	✓
1915(c) Children's Mental Health Services	✓	✓			✓			✓					✓	✓		

Through contracts with both affiliated and unaffiliated health plans, Aetna Medicaid administers or supports managed care health plans in Arizona, Florida, Kentucky, Illinois, Iowa, Louisiana, Maryland, Michigan, Missouri, Nebraska, New Jersey, New York, Ohio, Pennsylvania, Texas, Virginia, and West Virginia. The relationships we have developed with providers and organizations in our affiliate programs in Iowa's border states of Missouri, Nebraska, and Illinois will strengthen our resource base for Iowa operations.

Pioneer in Fully Integrated Care To deliver individually tailored service coordination and exceptional customer service to members, caregivers, and providers in our Iowa LTSS population, we will use the experience gained by Aetna Medicaid in more than 25 years of experience serving LTSS members in Arizona, Delaware, Florida, Illinois, Michigan, New Jersey, New York, and Ohio. We have honed our approach to serving highly complex and frail populations with diverse benefits. We are equipped to successfully manage the varying benefits, cost shares, and eligibility requirements of the Iowa LTSS and Home and Community-Based Services (HCBS) waiver populations.

For example, since 2001, Aetna Medicaid has administered a health plan in Arizona that manages LTSS services for nearly 12,000 members, 81% of whom are also dual-eligible members. Nationwide, we serve over 30,000 LTSS members in seven states. Our experience will equip us to build a managed LTSS program and successfully transition members into the program for the Agency. Please refer to our response to Attachment 5, Section 4 for details regarding our experience and capabilities serving members with LTSS needs as well as the results of several other LTSS programs.

We are also equipped to successfully manage the varying benefits, cost shares, and eligibility requirements of the Iowa LTSS and HCBS waiver populations. We will adapt our person-centered process to the unique needs of Iowans while meeting or exceeding the requirements specified by the Agency. We have the experience to do so: LTSS programs administered by Aetna Medicaid affiliated or administered health plans provide integrated LTSS, physical health, and behavioral health benefits.

NATIONWIDE QUALITY RECOGNITION

Currently, we have nine Medicaid plans with NCQA accreditation. Aetna, Inc. has another 182 accredited plans operating across the United States.

Table T4-2: Aetna Medicaid health plans with NCQA accreditation

Aetna Medicaid plans	Accreditation status
Florida, Michigan, Missouri, Virginia	Commendable
Kentucky, Nebraska, Pennsylvania, West Virginia	Accredited
Maryland	Interim

Aetna Medicaid plans	Accreditation status
Illinois, Louisiana, New Jersey, New York, Ohio, Texas	In process of preparing for or seeking accreditation

Aetna Better Health will pursue and achieve NCQA accreditation for Iowa as part of our operations under the Contract. Across Aetna Medicaid, we have multiple health plans above the national 90th percentile for Adult CAHPS for measurement year 2013 in the following composite and ratings questions:

- Getting Needed Care
- How Well Doctors Communicate
- Customer Service
- Rating of Personal Doctor
- Rating of Specialist
- Rating of All Health Care

Coordinating physical, behavioral health and LTSS services

Listen, Respect, and Act with Insight, Understanding, Compassion

Successful integration of physical and behavioral health services for members who have behavioral health challenges, including those with substance use disorders issues and other high-need populations, requires that the clinical teams share the same mission: **putting members' whole-health needs at the center**. This demands collaborative, integrated solutions that call for human interaction, innovative technology, and aligned incentives between the health plan and the provider network. Our care coordination programs will address *all* Medicaid members: members with physical conditions, behavioral conditions, or both; members with short-term, acute needs; and members with single or multiple chronic conditions.

The Aetna Medicaid Integrated Care Management (ICM) program was developed in 2010. Our ICM approach to care coordination is member-focused rather than disease-focused. It incorporates members' values, needs, and priorities using a culturally sensitive approach. We will capitalize on each member's strengths and supports and use motivational interviewing techniques to enhance communication and member engagement. We will involve providers, our members, advocates, community resources, and state agencies, including the Agency, to coordinate the physical, behavioral, and social needs of our members.

We will use a local, community-based, model for ICM, locating Case Managers in the communities they serve. Local presence spurs member engagement by facilitating in-person contact between Case Managers and members. Our community-based approach equips Case Managers with knowledge about the environment, providers, and resources in the community. For details regarding our care coordination strategies and initiatives for Iowa, please refer to our response to Attachment 5 to the RFP, Section 9.

OUR INTEGRATED CARE MANAGEMENT COMPLIMENTS OUR LONG TERM SERVICES AND SUPPORTS SERVICE DELIVERY APPROACH

Pioneer in Fully Integrated Care

We will use the knowledge gained in our 25 years of experience serving LTSS members in our Arizona, Florida, Illinois, Michigan, New Jersey, New York, and Ohio when implementing our ICM approach for our Iowa LTSS members to offer these members options for living in the setting or community of their choice. Through our experience in other states, we will help members stay out of institutional facilities and identify members who want to transition successfully back to the community.

Our ICM program recognizes that every person is best cared for holistically. ICM integrates every aspect of care—physical, behavioral, and functional—in a unified team and set of processes. It does so under one roof; Aetna Better Health **does not outsource program components.** Physical and Behavioral Health Clinicians, including Physicians, Registered Nurses and Advanced Practice Nurses, and Licensed Behavioral Health Specialists work face to face and side by side daily to identify members who have complex needs; assess and analyze their conditions; and coordinate with providers and community resources to deliver comprehensive health care and support.

We will use our expert Case Managers and our tried-and-tested integrated care management information system to connect the member, providers, and family to each other and to connect the member with an array of natural, community, and other supports. As an example, Aetna participates in one of the longest standing and innovative Managed Long Term Care Programs in the country, Arizona Long Term Care System (ALTCS). Rebalancing, in our book of business alone, resulted in a $13 million savings since 2010.

IMPLEMENTING NEW REIMBURSEMENT MODELS AND DECREASING COSTS THROUGH THE REDUCTION OF UNNECESSARY, INAPPROPRIATE, AND DUPLICATIVE SERVICES

Since 2007, Aetna Medicaid has offered Value Based Purchasing (VBP) arrangements that began with our pay-for-quality programs and later followed with our national Patient-Centered Medical Home (PCMH) model implemented in 2009. Aetna Medicaid has assisted providers in over 20 markets with delivery transformation focused on adopting patient-centered strategies including PCMH recognition with national vendors including NCQA. We will leverage this experience and knowledge for our Iowa provider network.

Quality and Value through
Simple, Relevant Solutions

In 2015, Aetna has over 1,000,000 members in PCMHs. Additionally; we have introduced shared-savings programs into our VBP toolkit, which includes projects in Arizona, Connecticut, Delaware, Maine, New York, Ohio, Pennsylvania, Maryland, Tennessee, and Utah.

Aetna, Inc. has publicly committed that 75% of the company's network contracts will be tied to value-based arrangements by 2020. Aetna Better Health commits to having 50% of our Iowa members with providers who are under value-based arrangements by 2018, exceeding the RFP requirements.

The intent of our VBP model is to move providers from the traditional fee-for-service (FFS) model to offer progressive pay-for-quality and pay-for-outcome models that reward providers for delivering high quality care and achieving on the triple aim of improved health of our members, improved member experience of care, and total reduction of cost. Our goals are consistent with Iowa's payment reform model, which will deliver on:

- Collaborating thoughtfully with providers to transform their approach and assist their efforts to become part of a high performing network that is truly patient-centered
- Supporting population-based care management, with providers assuming accountability for the overall care of their members
- Creating multiple performance-based, risk-sharing, and shared savings paths to account for differences, structures, and capabilities among providers
- Designing payment models for scalability from the outset that allow providers to individually pace adoption for operational or financial reasons

- Using an innovative, proprietary technology solution to align incentives for providers and drive quality of care

Please see Attachment 5: Sections 6.1.2 and 10.3 for additional details regarding our provider incentive programs; for additional details regarding our proposed billing and collections strategies, please refer to our response to RFP Attachment 5, Section 13.

Program integrity measures

Our Mission is to deliver a Medicaid compliance program that provides value to our customers. We will accomplish this mission by developing proactive monitoring and tracking systems designed to prevent, detect and correct conduct that violates the law or Aetna's value system. In doing so, we will give all our Medicaid staff the ability to achieve success while adhering to our high ethical standards. Aetna Medicaid's comprehensive fraud, waste, and abuse programs are part of larger program integrity and compliance programs that reflect our company's accountability and commitment to fiscal responsibility and good stewardship, as further demonstrated by the following:

- Aetna is a development collaborator of IBM's Fraud & Abuse Management System and helps develop solutions to identify, detect, and investigate fraud and abuse.
- Aetna is a founding member of the National Health Care Anti-Fraud Association (NHCAA) which is the leading national organization focused exclusively on the fight against health fraud.
- Aetna is a founding member of the Medical Identity Fraud Alliance, a cooperative specifically uniting all stakeholders in developing solutions and best practices for the prevention, detection, and remediation of medical identity fraud.
- Aetna is a member of CMS Health Care Fraud Prevention Partnership and CMS Healthcare Anti-Fraud Task Force.
- Aetna has 15 Fraud and Abuse staff with a professional designation of "Accredited Health Care Fraud Investigator."

Through the Fraud and Abuse Management System Hospital Model, Aetna's special investigations unit identified more than 200 facilities with questionable outlier behaviors. To date, the Special Investigations Unit has pinpointed more than $20 million in potential recoveries.

Innovative information technology solutions

Explore Ideas to Make the World a Better Place

The Aetna Medicaid information system infrastructure supports nearly 3 million members in 17 states through a fully integrated system that ensures data availability, integrity, and transparency across our business operations. Our infrastructure also powers our member and provider portals and our mobile applications and supports our commitment to health information exchange. Aetna Medicaid will support Aetna Better Health with industry standard information technology that has been developed and customized for the demanding and varied needs of Medicaid managed care programs:

- **QNXT™** is our core operating platform. A set of 28 integrated system modules track eligibility, adjudicate claims, manage benefit packages, and support other general member and provider data management and reporting. This system, in particular, was specifically designed and built to meet business administration needs for Medicaid and Aetna Medicaid configures and extends the system to support specific contract needs. EDM, the Encounter Data Management System, integrates with QNXT to manage the validation and submission of encounter data to the Agency.

- Our **Care Management System** is fully an integrated information system for physical and behavioral health care management and provides a complete suite of functional, physical, and behavioral health assessments, care planning tools, and monitoring functions. With this system, an Aetna Better Health Case Manager can develop a holistic picture of the member, create a care plan that meets the member's needs, goals, and desires, and follow up to evaluate a program's effectiveness and make appropriate changes when necessary. Through remote access capability, the Case Manager can do this while face to face with the member in the field, allowing him or her to immediately answer questions, verify information, and take action.

Aetna Medicaid's Information Technology support for Iowa offers two particular strengths:

1. **Predictive Modeling.** Consolidated Outreach and Risk Evaluation (CORE) is Aetna Medicaid's proprietary, evidence-based, custom-developed tool for identifying members who will benefit most from our ICM program. CORE identifies members who are most at-risk, and identifies members according to three high-risk groups: general high-risk, high-risk of an emergency department visit, and high-risk of an inpatient admission. CORE was developed specifically for use with the Medicaid population. A new capability added to CORE uses race and ethnicity factors to identify members who need outreach and management because of risk factors.
2. **Integrated Care Engine.** Aetna Medicaid has a dedicated data warehouse and analytics team. The warehouse—our Integrated Care Engine—aggregates data from many systems to provide reports and analytical capability to make better clinical and business decisions. It enables the predictive modeling capability of CORE. We designed this warehouse to meet the needs of Medicaid and can easily meet new needs as they arise; for example, integrating lab or radiology data. Using the Integrated Care Engine, our management team has the information to make effective decisions and to help DHS analyze program design changes when necessary.

The advantage of these systems is their ease of use: *the general technology market has made it clear that usable solutions—ones that make it easy for users to accomplish their tasks—trump those where users must work to get the answers.*

Committed to Health Care Transformation in Iowa

We frequently assess our technology as industry trends and standards evolve and may introduce new technology to Iowa, if appropriate, during the course of the Contract. Please refer to our response to RFP Attachment 5, Section 13 for details regarding our Information Technology offerings; however, throughout our proposal, we demonstrate our current technological capabilities that will meet the needs and requirements of the Iowa population.

Established Utilization and Quality Management systems

Aetna Medicaid has 30 years of experience in effectively and efficiently providing utilization management services through our affiliated health plans. As detailed in our response to Attachment 5: Section 11, we will leverage this expertise to implement our Utilization Management (UM) Program by:

- Applying established processes for managing, monitoring, evaluating, and improving the utilization of care and services members receive
- Assisting members, practitioners and providers in the appropriate utilization of care and service delivery systems, assessing information regarding satisfaction with these processes, and discovering opportunities to optimize members' health outcomes and manage costs
- Integrating medical and behavioral health care services using a biopsychosocial clinical model to evaluate the needs of each member

- Offering providers an integrated, secure web-based system through our UM Web Interface where they can submit all of the necessary information for an authorization request online. This comprehensive, rules-based utilization review and authorization system simplifies and automates the review process, providing timely responses to requests.
- Integrating our UM Program with our Quality Management and Improvement (QM/QI) program to align activities with the common principle of providing high quality, cost-effective, outcomes-oriented health care by balancing medical management, operations, and finance components

Do the Right Thing for the Right Reason

The Aetna Better Health Quality Management and Improvement (QM/QI) program will be a fully integrated program for managing, monitoring, evaluating, and improving the quality of care and services for all of our members. Our QM/QI efforts reach beyond the traditional health plan clinical quality approaches to incorporate technology and services that will deliver exemplary patient care, sustain excellence in organizational operations, and accelerate the transformation of health care. To this end, we have adopted the Agency for Healthcare Research and Quality's functional definition of quality as our overall goal: ***Doing the right thing for the right patient, at the right time, in the right way, to achieve the best possible results.*** Please refer to our response to Attachment 5: Section 10 for details regarding our Quality Management program and improvement strategies.

Aetna Better Health is the right choice for Iowa

Aetna Better Health is the right choice because we offer Iowa the best combination of features and services that can move the Initiatives to the next generation of health care. Our focus is aligned around improving health by increasing quality, access, and value.

Committed to Health Care Transformation in Iowa

We have invested in technology, built relationships, and created financial models to connect Iowa's systems, drive evidence-based care, and empower physicians and patients to collaborate effectively and adopt behaviors that follow clinical evidence and best practices. We advocate transforming the health care system and delivering affordable care, improved quality, and more convenience for members. We are creating solutions that will change the way health care is delivered in Iowa and finding ways to improve access to the health care people need when they need it at a cost they can afford.

As detailed throughout this proposal, we will:

- **Provide a fully integrated, in-house behavioral health integration solution** that considers all aspects of the member's physical and behavioral care needs with an advanced perspective on available solutions and programs, not one that is subcontracted, loosely integrated, or content to do the minimum level of evaluation and care coordination. We are collaborating with doctors, hospitals, pharmacies, labs, employers, members, and others to build a simpler, more integrated system centered on the individual. We will make it possible for care teams and patients to easily connect and have access to information when and where it's needed.
- **Offer a solution for secure, electronic sharing of clinical health information** that surpasses simple claims data feeds to provide what physicians and other providers need for good decision-making at the point of care. Further, we do it in a way that respects and supports the provider's current electronic health records capability. We will offer tools and resources—including a mobile health app—that allow members to connect directly with their health care team, take charge of their health, and manage their health care dollars.

- **Deliver services in a manner that promotes efficiency while providing high quality** and readily accessible services for members. We will offer evidence-based analytics and incentive plans to help providers give members the right care at the right time, with less duplication and hassle.

Not only will we bring the experience and knowledge to deliver the types of services sought by the RFP, we are committed to working with the Agency to build a healthier Iowa.

3.2.5.1.4 Letters of reference

3.2.5.1.4 Letters of reference from three (3) of the bidder's previous clients knowledgeable of the bidder's performance in providing services similar to those sought in this RFP, including a contact person, telephone number, and electronic mail address for each reference. It is preferred that letters of reference are provided for services that were procured in a competitive environment. Persons who are currently employed by the State, or who have been employed by the State in the past 5 years, are not eligible to be references.

Please see Appendix S for our Letters of Reference.

3.2.5.1.5 Experience managing subcontractors

Description of experience managing subcontractors, if bidder proposes to use subcontractors.

Three Decades of Caring for Those Most Vulnerable

Our preference is to contract with our affiliates; using Aetna affiliates as subcontractors is an approach that has been implemented in all Aetna Medicaid markets. Aetna Medicaid will be the primary subcontractor for our Iowa operations. Aetna Life Insurance Company will provide procurement management. Aetna Health Management, LLC will support provider credentialing. Using affiliates allows us to achieve economies of scale, consistency in our management and delivery approach, and provides us an advantage when negotiating rates. Figure T4-2 shows Aetna Better Health, our parent organizations, and affiliates providing services under this Contract.

Aetna Better Health will use this team of affiliated subcontractors together with select unaffiliated subcontractors that have established a positive presence in Iowa or have established a successful relationship with Aetna Medicaid in other Medicaid managed care markets. This approach will allow us to achieve similar success during implementation and through the transition to steady state operations.

Figure T4-2: [redacted] **-CONFIDENTIAL**

[redacted]

Please reference our response to RFP Attachment 5, Section 2.2 for a detailed description regarding our proposed subcontracting relationships for the Iowa program. This model of a local, community-based health plan supported by Aetna Medicaid will benefit our Iowa members threefold, by providing a:

1. Local focus
2. Large fund of knowledge and experience
3. National resource base

Our primary considerations as we select non-affiliated subcontractors are service, cost, and compliance. We will select and use non-affiliated subcontractors only when we are certain the subcontractor will perform the services as well as—or better than—we would be able to, due to:

- Established service relationships with our members and providers
- Specific experience or expertise
- Greater capacity

As Table T4-3 demonstrates, we have selected subcontractors with which we have established a rapport of trust and stability through the longevity of our relationship to serve our Iowa members.

[redacted] CONFIDENTIAL

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[redacted]	[redacted]

We will require our subcontractors to demonstrate adherence to our health plan standards, those of the NCQA, and that they follow all applicable federal and Iowa laws and regulations. We will establish and follow procedures to comply fully with all applicable requirements of the RFP regarding subcontractors, as detailed in Attachment 1, Section 2.2, Subcontracts, as we evaluate, select, negotiate, execute agreements with, and manage all subcontractors and subcontracted work.

3.2.5.2 PERSONNEL

3.2.5.2.1 Tables of organization

Illustrate the lines of authority in two tables:

- **One showing overall operations**
- **One showing staff who will provide services under the RFP**

A staffing plan responsive to our members' changing needs

Pioneer in Fully Integrated Care

The information shown below in Figures T4-3 through T4-6 represents Aetna Better Health's staffing reporting structure and Table T4-4 provides our staffing plan to deliver services under our contract with the Iowa High Quality Healthcare Initiative. Our plan will meet or exceed all requirements described in Attachment 1: Sections 2.8 and 2.9 of the RFP and shows our commitment to provide high quality, culturally competent services to our members, providers, and their communities.

Figure T4-3 below illustrates our lines of authority governing overall operations while Table T4-4 provides our Staffing Plan, including designations of Key Personnel/positions.

Figures T4-4, T4-5 and T4-6 illustrate lines of authority for staff to key personnel that will provide services under this RFP.

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3.2.5.2.2 Names and credentials of key corporate personnel

- **Include the names and credentials of the owners and executives of your organization and, if applicable, their roles on this project.**
- **Include names of the current board of directors, or names of all partners, as applicable.**
- **See Attachment 1: Scope of Work Section 2.9.3 for details for requirements for submitting information and resumes for key personnel who will be involved in executing this contract.**

Aetna Better Health of Iowa Inc. is a wholly owned subsidiary of Aetna Health Holdings, LLC, which is a wholly owned subsidiary of Aetna Inc. Aetna Inc. (Aetna) is one of the nation's leading diversified health care benefits companies. Established in 1853, it has more than 160 years of experience serving approximately 37.3 million members. Aetna reported 2014 gross revenues in excess of $58 billion. The experience of Aetna Inc.'s and Aetna Health Holdings' subsidiaries who own or administer Medicaid/CHIP contracts, as well as any role that Aetna Inc. itself will play in this project, is described in detail throughout our response to this RFP.

Table T4-5 details the names and credentials of board of directors that will serve Aetna Better Health once incorporated. Aetna Better Health will be a corporation and therefore will not have any partners. The names, credentials, and other details for our executives are found in Table T4-6 in response to Section 3.2.5.2.3.

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3.2.5.2.3 Information about key project personnel

Provide name and a general description of proposed Key Personnel as set forth in Section 2.9.3 of RFP Attachment 1, Scope of Work. Include the qualifications, number of years of experience in their field, and the proposed location from which the position shall be based. Provide resumes for each of these Key Personnel behind Tab 6 of the Bid Proposal. If the key staff person is not yet identified, state so in the response to this subsection.

We are basing our approach to development of an organization to serve Iowa's members on Aetna Medicaid's experience creating, implementing, and operating Medicaid managed care programs in 17 states: **we place the member at the center of everything we do.**

We will build our care and service teams to seamlessly support our members throughout their experience with us and will staff all key positions described in RFP Section 2.8 and 2.9, on an interim basis as detailed in Table T4-6, on the pages that follow. We are in the process of recruiting for permanent employees and will provide updates to the Agency within the requested timeframes. In recruiting and hiring permanent empoyees, we will have a local presence and confirm that all staff is knowledgeable in Iowa-specific policies and operations through initial and ongoing required training. Staff delivering care coordination services will be based in Iowa at locations that facilitate the delivery of in-person services as appropriate.

Behind Tab 6 of the Bid Proposal, please find a tab titled "3.2.7.3 Resumes", where we have provided resumes for each individual who will fill these roles on an interim basis.

Please refer to our Response to RFP Sections 2.8 and 2.9 for additional details regarding our Organizational Structure and Staffing Plan.

Local Based Plan All key project personnel will be located in Iowa with the exception of the Claims Administrator.

Table T4-6: Position descriptions and qualifications

Position	Name	General description	Qualifications and years of experience
Contract Administrator (CEO)	Janet Grant	• Responsible for overseeing the entire operations of the Contractor. • With COO, has full and final responsibility for contract compliance.	• Bachelor of Social Work, Minnesota State University at Moorhead • Master of Business Administration, Wright State University • *Years of experience: 34 years, the last 14 in Medicaid managed care executive roles*
Chief Operating Officer (COO)	Eileen Shaw	• Responsible for overseeing the entire operations of the Contractor. • With CEO, has full and final responsibility for contract compliance.	• A.A.S. in Nursing • Licensed Registered Nurse – Arizona, New York • Certified in Case Management, Quality Management, Care Management and Disease Management • *Years of experience: 7 years acting as interim health plan Chief Operating Officer*
Medical Director (CMO)	Barry Markman, MD	• Responsible for leadership of strategic medical management activities that contribute to the performance of the markets and promote quality of care for our members. • Development and implementation of medical programs/policies, enhancing relationships with providers and facilities, plan sponsors and regulatory agencies and acts as a key business ally in network development, product design, strategic planning and sales support • Responsible for oversight of all clinical functions including, disease management and care coordination programs, the development of clinical care guidelines and utilization management. • Responsible for the coordination and implementation of the Quality Management and Improvement Program. • Attends and participates in any scheduled quality committee meetings as directed by the Agency. • Directs internal utilization management committee.	• An Iowa-licensed physician in good standing • Demonstrated ability to make strategic decisions based on a thorough understanding of industry issues, trends and the regulatory landscape • Demonstrated ability to create business strategy to drive competitive advantage and shift direction as market conditions dictate • Demonstrated ability to interact successfully with external providers • *Years of experience: 4 years*

Position	Name	General description	Qualifications and years of experience
Behavioral Health Medical Director*	Dr. Chandra Kee	• Work in both fully integrated health plans and carve-outs. • Collaborate with both community organizations and external stakeholders	• Bachelor of Science, Indiana University of PA • Doctor of Medicine, Robert Wood Johnson Medical School • Extensive experience on both the physical health and behavioral health side • *Years of experience: 22 years*
Chief Financial Officer	Debra Bacon	• Responsible for overseeing the budget, accounting systems and financial reporting for the Program.	• Bachelors of Science, University of Nebraska • Master's Degree, University of Nebraska • Certified Public Accountant Permit, Nebraska State Board of Public Accountancy • *Years of experience: 23 years in finance; 12 years in Medicaid*
Compliance Officer	Patricia Simpson	• Manage compliance efforts with state and federal laws, contract, regulations and related company-policies • Monitor plan compliance through monthly monitoring of plan metrics, quarterly assessments and auditing if needed • Primary liaison with the State (or its designees) to facilitate communications between the Agency, the State's contractors and our executive leadership and staff • Has primary responsibility for ensuring compliance with the terms of the Contract.	• Direct experience working in a relevant federal agency, or compliance, legal, or audit experience in a Medicaid or Medicare managed care plan • Leadership in driving a culture of compliance, collaborating for results, creating accountability, and promoting continuous quality improvement • Current knowledge of federal and state legislation, legislative initiatives and regulations that may impact the program • *Years of Experience: Over 10 years*

* While this position was not identified as Key Personnel in RFP Section 2.9.3, we feel strongly that Dr. Kee can provide valuable support at the Corporate level in the capacity indicated.

Position	Name	General description	Qualifications and years of experience
Pharmacy Director/Coordinator (Pharmacist)	Ted Cummings	• Oversees the pharmacy benefits under the Contract • Direct the activities of the pharmacy directors for each Plan • Oversight and coordination of all Contractor and Pharmacy Benefit Manager (PBM) pharmacy requirements including drug rebate. • Attends the Agency Pharmaceutical & Therapeutics (P&T) Committee and Drug Utilization Review (DUR) Commission meetings • Provide direction and assistance to allow the pharmacy directors to make certain that we are providing appropriate oversight for the prescription drug benefit • Serve as the primary contact for new plans during the RFP process and help prepare the plan for go-live • Make certain that we are following all regulations and all elements of the contract with the state	• Iowa licensed pharmacist • Experience as a Medicaid Pharmacy Director or equivalent Medicaid pharmacy experience, inclusive of drug rebate • Advanced knowledge of complex medical, technical, statistical, and process components relating to Utilization Review, QM, and Case Management pharmaceutical requirements • Ability to perform detailed and disciplined work using standard methodologies in analysis, design, development, evaluation, testing, documentation, and implementation in support of health care goals • Ability to read, comprehend, and follow technical reports and instructions containing concrete or abstract variables at an advanced level • Experience writing correspondence, proposals, reviews, audit analysis, and technical documentation, and presenting information to staff effectively in one-on-one and small group settings • *Years of experience: 25 years*
Grievance and Appeals Manager	Patrice Stevens	• Accountable for the design, development and implementation of member and provider appeal and grievance programs for new Medicaid and Integrated Duals health plans as well as the ongoing management and support of appeal and grievance systems and processes for Medicaid and Integrated Duals plans • Manages our grievance and appeals process, ensuring compliance with processing timelines and policy and procedure adherence	• Excellent written and verbal communication skills • Effective analytical and problem-solving skills; ability to make some independent decisions • Effective planning and organizational skills • Excellent presentation skills • *Years of experience: 7 years*

Position	Name	General description	Qualifications and years of experience
Quality Management Manager/Director of Quality Management	Kim Herink	• Responsible for the oversight and coordination of Medicaid health plans quality management programs and activities, including: risk management, patient safety, credentialing, accreditation, practitioner peer review, external quality review organization evaluations, quality focus studies, and improvement projects • Oversees our Quality Management and Improvement program • Ensures compliance with quality management requirements and quality improvement initiatives	• Iowa licensed registered nurse • Management experience in the health care industry across high performing teams with quantifiable positive outcomes • Highly organized with a strong sense of personal accountability and an inherent need to influence change and drive forward progress • *Years of experience: 17 years of managed health plan QM/QI experience*
Utilization Management Manager/Director of Utilization Management	Sherry Logan, RN	• Development and Management of Medicaid UM Standard Operating Model • Development and Management of Medicaid UM Standard Staffing Model • Manages all elements of our utilization management program and staff under the supervision of the Medical Director • Co-Chairperson National Medicaid UM Steering Committee • Support for New Business Implementation and for Existing Health Plans	• Must be an Iowa licensed registered nurse, physician or physician's assistant if required to make medical necessity determinations. • Must have skills in management, application of clinical criteria, negotiating program development with providers and problem solving • Knowledge of regulations related to utilization management • Ability to write correspondence, procedures and policies, schedules, supporting documentation, and budgets, and present information effectively in one-on-one and small group settings to providers and employees • The abilities to handle multiple priorities, use advanced reason to define problems, collect data, establish fact, draw valid conclusions, and design, implement, and manage appropriate action plans are required • *Years of experience: 20 years*

Position	Name	General description	Qualifications and years of experience

Behavioral Health Manager	Heather Koch	• Responsible for ensuring that our behavioral health operations, which include the operations of any behavioral health subcontractors, are in compliance with the terms of the Contract
		• Coordinates with all functional areas, including quality management, utilization management, network development and management, provider relations, member outreach and education, member services, contract compliance and reporting
		• Responsible for the oversight and execution of behavioral health programs and services, on a stand-alone and integrated basis, in order to:
		  ◦ Make certain members are receiving the care they require
		  ◦ The organization is providing responsive, effective and quality management of the service delivery processes, including assurance of appropriate and accessible providers are available for these purposes
		  ◦ The organization is complying with and meeting all contractual obligations
			• Masters in Counseling, University of Phoenix (CACREP approved program)
			• Bachelor of Arts in Psychology, Ottawa University
			• *Years of experience: 19 years*

Member Services Manager	Michelle Duncan	• Responsible for oversight of the member services functions of the Contract, including member helpline telephone performance, member e-mail communications, member education, the member website, member outreach programs, development, approval and distribution of member materials. • Oversight of the interface with the State or its subcontractors regarding such issues as member enrollment and disenrollment	• Business Administration/Paralegal, Heald College • Management and Supervisory Development, Portland Community College • *Years of Experience: 15 years*

Position	Name	General description	Qualifications and years of experience
Provider Services Manager	Donette Koehler	• Responsible for the oversight of the provider services function of the Contract including contracting and credentialing • Coordination of communications between Aetna Better Health and our subcontracted providers • Management and adjudication of member and provider disputes arising under the grievance system including member grievances, appeals and requests for hearing and provider claim and disputes • Oversight of member and Provider Call Centers, Claims, Encounters, Provider Services, Appeals and Grievances, Prior Authorizations, Enrollment, Outreach, Data Analytics, Marketing and Application Support • Development and implementation of operational policies and procedures that can streamline the unit when necessary and yield improved operational metrics • Working with the data analysis and application development groups when appropriate to design, develop and deploy systems that contribute to and enhance corporate knowledge and efficiency	• Major program development experience in support of network management and provider contracting operations • In-depth knowledge of managed care business and health care environment; Medicaid managed care experience preferred • Working knowledge of managed care health plan operations, with a focus on provider business operations • Strong analytical and written and verbal communication, and presentation skills • Substantial financial management background • Demonstrated ability to work across and with staff at all levels of the health plan organization • *Years of experience: 19 years*
Information Systems Manager/Information Systems Coordinator	Rhiannon Yandell	• Direct the implementation and delivery of information and transaction products • Facilitate business requirement development and monitor Information Technology project status • Act as a business technical expert with the planning, development and validation of master and detail test plans and strategies • Ensures all information system security and controls, program data transactions, data exchanges other information system requirements are in compliance with the terms of the Contract, and all data submissions required for federal reporting • Serves as a liaison between Aetna Better Health and the Agency, or its designee, regarding encounter claims submissions, capitation payment, member eligibility, enrollment and other data transmission interface and management issues	• Detailed knowledge and understanding of the systems development life cycle, the business owners' functions and systems, and application program development alternatives • Excellent written and oral communication skills • Ability to work effectively with all internal and external customers and IT management teams and staff • *Years of experience: 14 years*

Position	Name	General description	Qualifications and years of experience
Claims Administrator	Colleen Gurule	• Promotes prompt and accurate provider claims processing in accordance with the terms of the Contract • Implements and enforces department operational standards, procedures, and policies to achieve and increase target production goals; recommends initiatives and programs to optimize and improve the unit's proficiency, or performance enhancing technology and procedures relating to the Encounter Management System • Monitors Encounter Unit performance, productivity, and accuracy by measurement systems and benchmarking; rewards and reprimands as necessary • Analyzes and prioritizes encounter-correction requirements and appropriately allocates Encounter Unit technical and correction resources • Develops and disseminates management reports and statements, detailing performance, production, quality, etc. • Maintains documentation of each State's Medicaid-encounter requirements including but not limited to; file lay outs; edits; submission timelines; contact names and numbers	• Experience with Medicare, Medicaid, and commercial (including self-funded) managed care programs as relating to claims administration preferred • Effective communications and interpersonal skills, maturity, and good judgment are required • Working experience with automated managed health care software is required • This position requires work experience in a complex, competitive environment with diverse racial and socioeconomic factors • *Years of experience: 35 years Managed Care, 15 years Claims*
Care Coordination Manager	Kelly DeFrancisco, MSW	• National Director of Integrated Care Management (ICM) for Aetna Medicaid: oversight for the development, implementation and monitoring of the ICM program across all Medicaid lines of business • Oversight of care coordination and community-based case management programs • Oversight for the development and maintenance of policies, procedures • Develop and monitor program metrics and dashboards across all lines of business	• Degreed Social Worker or Registered Nurse • Bachelor's degree in social work, nursing, health administration, or other health-related field • Master's degree preferred • *Years of experience: 24 years*
Program Integrity Manager	To Be Hired	• Responsible for oversight of the special investigations unit (SIU) activity. • Serve as the liaison between the Contractor and state agencies, law enforcement, and federal agencies.	• Informed of current trends in fraud, waste, and abuse as well as mechanisms to detect such activity.

Position	Name	General description	Qualifications and years of experience
Long Term Care Manager	Patricia Wright	• LTSS Program development and team management • Plan and program Implementation • Oversight of the implantation of the state's community based and facility programs • Directs and manage plans and programs for multiple high-risk populations, Medicaid waivers, and Medicare SNP programs including HIV/AIDs, transplant, neonatal, Dual SNP, ABD, and acute long term care • Responsible for overseeing long-term care provider reviews, utilization reviews, member satisfaction surveys, and member health and welfare	• Bachelor of Social Work, West Chester University • Behavioral Health Director: *5 years* (Medicaid) • LTSS *4 years*
SIM Grant Liaison	To Be Hired	• Acts as the primary point of contact with the Agency for delivery system reform activities, including managing a specific project plan and reporting on activity and progress towards identified goals • Serves as the liaison between the MCO and various state agencies, leaders from the health care delivery system, other payers, stakeholders, and federal agencies in matters related to health care delivery system transformation described in SIM.	• Must be informed of current trends in delivery system reports • Must have specific experience within the health care delivery system in Iowa

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3.2.5.4 Termination, Litigation, and Investigation

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3.2.5.4 TERMINATION, LITIGATION, AND INVESTIGATION

Termination, litigation, and investigation

Bid Proposals must indicate whether any of the following conditions have been applicable to the bidder, or a holding company, parent company, subsidiary, or intermediary company of the bidder during the past five (5) years that relate to services contemplated by this RFP unless otherwise noted. If any of the following conditions are applicable, then the bidder shall state the details of the occurrence. If none of these conditions is applicable to the bidder, the bidder shall so indicate.

List any contract for services that the bidder has had that was terminated for convenience, non-performance, non-allocation of funds, or any other reason for which termination occurred before completion of all obligations under the contract provisions.

The bidder, Aetna Better Health of Iowa Inc. is not yet operational and accordingly has not had any contract for services terminated. Neither Aetna Better Health of Iowa's direct parent, Aetna Health Holdings, LLC, its ultimate parent Aetna Inc., nor any affiliate or subsidiary providing services for Medicaid, CHIP or other low income populations has had a contract for services terminated for convenience, non-performance, non-allocation of funds, or any other reason for which termination occurred before completion of all obligations under the contract provisions. None of Aetna Medicaid's affiliates has had a contract supporting a Medicaid plan unilaterally terminated by the counterparty or not renewed based on our performance. For information regarding terminations without cause and non-renewals for contracts for services involving Medicaid, CHIP or other publicly funded low income populations please refer to Table T6-2 set forth in response to Question 2 of Section 3.2.7.4.2, titled "Tables." The table is designated under the "Applicable Question" column as "3.2.5.4 – *Contract terminations and non-renewals for Aetna Medicaid.* Information in that table may not be specifically responsive to this question; however, it is provided out of an abundance of caution and to facilitate complete transparency.

List any occurrences where the bidder has either been subject to default or has received notice of default or failure to perform on a contract. Provide full details related to the default or notice of default including the other party's name, address, and telephone number.

The bidder, Aetna Better Health of Iowa Inc., is not yet operational and accordingly has not been subject to default or received notice of default or failure to perform on a contract. For information regarding defaults or notices of default or failure to perform on a contract that relate to the Medicaid and CHIP services contemplated by this RFP for Aetna Better Health of Iowa's parent companies, or their subsidiaries, including a holding company or intermediary company of the bidder and any health plans administered by Aetna Medicaid, please refer to Table T6-2 set forth in response to Question 2 of Section 3.2.7.4.2, titled "Tables." Information in that table that is responsive to this question is designated under the "Applicable Question" column as "3.2.5.4 –Default.

List any damages, penalties, disincentives assessed, or payments withheld, or anything of value traded or given up by the bidder under any of its existing or past contracts as it relates to services performed that are similar to the services contemplated by this RFP. Include the estimated cost of that incident to the bidder with the details of the occurrence.

The bidder, Aetna Better Health of Iowa Inc., is not yet operational and accordingly has not been assessed any damages, penalties, disincentives, payments withheld, nor has it traded or given up anything of value. For information regarding damages, penalties, or disincentives assessed, payments

withheld, or anything of value traded or given up that relate to the Medicaid and CHIP services contemplated by this RFP for Aetna Better Health of Iowa's parent companies or their subsidiaries, including a holding company or intermediary company of the bidder and any health plans administered by Aetna Medicaid, please refer to Table T6-2 set forth in response to Question 2 of Section 3.2.7.4.2, titled "Tables." Information in that table that is responsive to this question is designated under the "Applicable Question" column as "3.2.5.4 –Damages/Fines."

List and summarize any current pending or threatened litigation, administrative or regulatory proceedings, or similar matters related to the subject matter of the services sought in this RFP. Bidders may limit disclosure of these matters to a material threshold established by GAAP requirements.

Aetna Better Health of Iowa Inc. is not yet operational and accordingly it has no current pending or threatened litigation, administrative or regulatory proceedings, or other similar matters.

Furthermore, there is no current pending or threatened material litigation, administrative proceedings, or similar matters relating to the Medicaid and CHIP services contemplated by this RFP for Aetna Better Health of Iowa's parent companies or their subsidiaries, including a holding company or intermediary company of the bidder.

List any irregularities that have been discovered in any of the accounts maintained by the bidder on behalf of others. Describe the circumstances of irregularities or variances and detail how the issues were resolved.

Aetna Inc.'s Annual Report on Form 10-K, which comprises all of the Company's consolidated financial statements, received an unqualified opinion from the audit firm KPMG LLP from 2010-2014. Additionally, KPMG concluded that the Company maintained, in all material respects, effective internal controls over financial reporting over that same time period. Refer to page 141 of Aetna Inc.'s 2014 Annual Report on Form 10-K, in the Financial Statements binder, for an example of KPMG's opinion.

List any details of whether the bidder or any owners, officers, primary partners, staff providing services or any owners, officers, primary partners, or staff providing services of any subcontractor who may be involved with providing the services sought in this RFP, have ever had a founded child or dependent adult abuse report, or been convicted of a felony. Staff providing services shall include anyone having contact with members or member data.

For Aetna Better Health of Iowa Inc. and its affiliated subcontractors, Aetna Medicaid Administrators LLC, Aetna Health Management, LLC, and Aetna Life Insurance Company, we have no knowledge of any owners, officers, primary partners, or any staff providing services who would have contact with Iowa Medicaid members or member data ever having a founded child or dependent adult abuse report or ever having been convicted of a felony. Our company policies require that prior to employment all applicants of any Aetna affiliated company are subject to a background check and a drug test. Applicants who are convicted of felonies under the Violent Crime Control and Law Enforcement Act of 1994 are barred from employment. In addition, all employees are checked monthly against the Office of Inspector General and the General Service Administration exclusions lists, which include enumerated felonies and patient abuse or neglect. Applicants are checked daily against the Office of Foreign Assets Control list. Pursuant to federal law, no officers, directors, primary partners, or staff providing services who appear on either list will work on the Medicaid/CHIP business for Aetna Better Health of Iowa.. Finally, company policy also requires all employees to report felony convictions to the company immediately. Once a year

that reporting requirement is supplemented by requiring all employees to certify that they have not been convicted of a felony in the past 12 months.

Regarding our unaffiliated subcontractors, this requirement will be included in our subcontracting agreements. We are aware of our continuing obligation to report these matters and will make certain that our unaffiliated subcontractors are as well.

Aetna Better Health of Iowa is a corporation, not a partnership, and therefore has no primary partners that have ever had a founded child or dependent adult abuse report or have been convicted of a felony.

Aetna Better Health of Iowa's direct parent is Aetna Health Holdings, LLC, and its ultimate parent is Aetna Inc. Neither corporate entity has ever been convicted of a felony or had a founded child or dependent adult abuse report.

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Appendix S

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COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CYNTHIA B. JONES
DIRECTOR

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600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

April 16, 2015

Carrie Lindgren
Iowa Department of Human Services
Hoover Building, 1st Floor
1305 East Walnut Street
Des Moines, Iowa 50309-0114

Re: Letter of Reference, Iowa High Quality Healthcare Initiative
RFP# MED-16-009

Dear Ms. Lindgren:

This letter is intended to serve as a reference for Aetna Better Health of Iowa, which is a bidder responding to the Iowa Department of Human Services' Request for Proposal (RFP) for the Iowa High Quality Healthcare Initiative, RFP# MED-16-009. Aetna Better Health of Iowa is a subsidiary of Aetna Medicaid Administrators, LLC (Aetna Medicaid). Aetna Medicaid is an affiliate of CoventryCares of Virginia and provides services to this Agency under a Medicaid managed care contract that was awarded during a competitive procurement process.

CoventryCares of Virginia has held a contract with the Department of Medical Assistance Services (DMAS) since 1996 and are in full compliance with all contract deliverables and requirements. CoventryCares of Virginia serves TANF, ABD, SSI and CHIP members. We have found Aetna Medicaid to be a valuable partner in our efforts to deliver high quality, cost-effective care to Medicaid recipients.

CoventryCares has been our highest ranked health plan in Virginia by NCQA for several years. We attribute this to the member focus of their care management teams, the personal touch and coordination of resources offered to members through CoventryCare's outreach team and the personal commitment of the senior leadership with time and funding to support the Department's broader initiatives including the State Innovation Model (SIM) grant and program integrity to improve Virginia Medicaid.

CoventryCares of Virginia has worked collaboratively with the Department over the past nineteen (19) years as the Commonwealth moved forward with initiatives that reformed and enhanced managed care operations with the ultimate goal of providing access to quality care for Medicaid beneficiaries in Virginia. More recently, CoventryCares worked successfully with the Department to transition special populations, previously excluded from managed care participation, into the health plan. CoventryCares staff have closely monitored these populations (foster care/adoption assistance children, and recipients enrolled in home and community-based waivers) to ensure their health care needs are met in a timely manner. CoventryCares has always been extremely responsive and has provided exceptional case management services for special populations.

If you have questions or require further information about CoventryCares of Virginia or Aetna Medicaid's performance as a contractor for this Agency, I can be reached at cheryl.roberts@dmas.virginia.gov or 804-786-6147.

Sincerely,

Cheryl J. Roberts, J.D.
Deputy Director of Programs

Missouri Department of
SOCIAL SERVICES
Your Potential. Our Support.

JEREMIAH W. (JAY) NIXON, GOVERNOR • BRIAN KINKADE, DIRECTOR

MO HEALTHNET DIVISION
P.O. BOX 6500 • JEFFERSON CITY, MO 65102-6500
WWW.DSS.MO.GOV • 573-751-3425

April 27, 2015

Carrie Lindgren
Iowa Department of Human Services
Hoover Building, 1st Floor
1305 East Walnut Street
Des Moines, Iowa 50309-0114

RE: LETTER OF REFERENCE, IOWA HIGH QUALITY HEALTHCARE INITIATIVE
RFP# MED-16-009

Dear Ms. Lindgren:

This letter is intended to serve as a reference for Aetna Better Health of Iowa, which is a bidder responding to the Iowa Department of Human Services' Request for Proposal for the Iowa High Quality Healthcare Initiative, RFP# MED-16-009. Aetna Better Health of Iowa is a subsidiary of Aetna Medicaid Administrators, LLC (Aetna Medicaid). Aetna Medicaid is an affiliate of HealthCare USA and provides services to this Agency under a Medicaid managed care contract that was awarded during a competitive procurement process.

HealthCare USA has held a contract with the State of Missouri since 1995. HealthCare USA serves TANF and CHIP members. We have found Aetna Medicaid to be a valuable partner in our efforts to deliver high quality, cost-effective care to Medicaid recipients. HealthCare USA and Aetna Medicaid are in full compliance with all contract requirements.

If you have questions or require further information about HealthCare USA's or Aetna Medicaid's performance as a contractor for the State of Missouri, I can be reached via email at Susan.M.Eggen@dss.mo.gov or via phone at 573-526-4274.

Sincerely,

Susan M. Eggen
Assistant Deputy Director - MO HealthNet Managed Care

Interpretive services are available by calling the Participant Services Unit at 1-800-392-2161.
Prevodilačke usluge su dostupne pozivom odjela koji učestvuje u ovom servisu na broj 1-800-392-2161.
Servicios Intrepretive están disponibles llamando a la unidad de servicios de los participantes al 1-800-392-2161.
RELAY MISSOURI
FOR HEARING AND SPEECH IMPAIRED 1-800-735-2466 VOICE • 1-800-735-2966 TEXT PHONE
An Equal Opportunity Employer, services provided on a nondiscriminatory basis.

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

April 30, 2015

Ms. Carrie Lindgren
Iowa Department of Human Services
Hoover Building, 1st Floor
1305 East Walnut Street
Des Moines, Iowa 50309-0114

RE: LETTER OF REFERENCE, IOWA HIGH QUALITY HEALTHCARE INITIATIVE
RFP# MED-16-009

Dear Ms. Lindgren:

This letter is intended to serve as a reference for Aetna Better Health of Iowa, which is a bidder responding to the Iowa Department of Human Services' Request for Proposal for the Iowa High Quality Healthcare Initiative, RFP# MED-16-009. Aetna Better Health of Iowa is a subsidiary of Aetna Medicaid Administrators, LLC (Aetna Medicaid). Aetna Medicaid is an affiliate of Aetna Better Health of Louisiana (ABLA) and provides core benefits and services included in the Louisiana Medicaid State Plan for the Department Health of Hospitals (DHH) under a full risk-bearing Medicaid managed care contract that was awarded during a competitive procurement process.

The ABLA contract with DHH went into effect February 1, 2015, currently serving TANF, ABD, and CHIP members. We anticipate Aetna Medicaid to continue to be a valuable partner in our efforts to deliver high quality, cost-effective care for our Medicaid recipients while maintaining accountability to Louisiana taxpayers. Aetna Better Health of Louisiana and Aetna Medicaid are in full compliance with implementation contract requirements minus some localized staffing concerns. At this time we have minimal data on performance to extend a fully qualified recommendation beyond our implementation timeline. However, our experience with Aetna has been positive and encouraging as we look forward to building a long-term successful partnership.

If you have questions or require further information about Aetna Better Health of Louisiana's or Aetna Medicaid's performance as a contractor for this Agency, I may be reached at Ruth.Kennedy@la.gov or (225) 342-3032.

Sincerely,

J. Ruth Kennedy
Medicaid Director
Bureau of Health Services Financing
Louisiana Department of Health and Hospitals

Bienville Building • 628 North 4th Street • P.O. Box 91030 • Baton Rouge, Louisiana 70821-9030
Phone #: 225/342-9240 • Fax #: 225/342-9508 • www.MakingMedicaidBetter.com
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Tab 5: Attachments

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Appendix B

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2.5.3 Iowa Medicaid Ownership and Control Disclosure

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Iowa Department of Human Services

Iowa Medicaid Ownership and Control Disclosure

Provider Name	Federal Tax ID or SSN
Aetna Better Health of Iowa Inc.	47-3850677

Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.

It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. *See* Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN).

In the questions that follow, the provider listed above is referred to as "You" or "Your."

Section 1: Provider Type

Are you an individual practitioner or a group of practitioners?

Individual Practitioner: ☐ Yes or ☒ No

Group of Individual Practitioners ☐ Yes or ☒ No

If you answered "Yes" and you are an individual practitioner or a group of individual practitioners, please skip to Section 5. The ownership disclosure requirements do not apply to these entities that generally do not have owners, such as individual practitioner or groups of practitioners.

If you answered "No" because your entity is some form of business other than an individual practitioner or a group of practitioners, please complete all sections.

Section 2: Ownership

Individual Ownership

Please list in the following table all ***individuals*** with an ownership or control interest in you. Include each person's name, address, date of birth (DOB), and SSN, title (e.g., chief executive office, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of your organization if you are organized as a corporation; or
f) is a partner in your organization if organized as a partnership.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
Pamela S. Sedmak	Director, CEO and President	N/A	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	[redacted]	*
Debra J. Bacon	Director	N/A	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	[redacted]	*
Janet R. Grant	Director	N/A	10 South Broadway, Ste. 1200 St Louis MO 63102	[redacted]	*
Elaine R. Cofrancesco	Vice President and Treasurer	N/A	151 Farmington Ave. Hartford, CT 06156	[redacted]	*

* Refer to P.L. 93-579, Disclosure of Social Security Account Number

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of you if organized as a corporation; or
f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
Aetna Health Holdings, LLC	30-0123754	100% Direct Owner	151 Farmington Ave. Hartford, CT 06156	N/A	N/A
Aetna Inc.	23-2229683	100% Indirect Owner	151 Farmington Ave. Hartford, CT 06156	Refer to the attached for a listing of Aetna offices	N/A

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
Robert M. Kessler	Vice President and Secretary	N/A	151 Farmington Ave. Hartford, CT 06156	[redacted]	*
Brian C. Winters	Assistant Controller	N/A	304 Jefferson Ct. Collegeville, PA 19426	[redacted]	*
Kevin J. Casey	Senior Investment Officer	N/A	151 Farmington Ave. Hartford, CT 06156	[redacted]	*
Steven Conte	Principal Financial Officer & Controller	N/A	151 Farmington Ave. Hartford, CT 06156	[redacted]	*

* Refer to P.L. 93-579, Disclosure of Social Security Account Number

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of you if organized as a corporation; or
f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 3: Subcontractors

Name of Subcontractor	TIN/SSN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
Not Applicable					

Section 3: Individual Relationships

If you listed in Table 1 any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? ☐ Yes or ☒ No

If you answered Yes, please provide all of the following information about each individual owner in the table below.

Table 4:

Social Security Number	Person Name	Relationship	Date of Birth
Not Applicable			

If you listed in Table 1 any individual owners of you and also listed in Table 3 subcontractors in which you have an ownership interest, are any of the individual owners listed in Table 1 related to any owner of any subcontractors listed in Table 3 as a spouse, parent, child or sibling?

☐ Yes or ☒ No

If you answered Yes, please provide all of the following information about each individual owner in the following table.

Table 5:

Social Security Number	Person Name	Relationship	Date of Birth
Not Applicable			

Please copy this page if additional space is needed.

Section 4: Other Disclosing Entities

Do any owners of you have an ownership or control interest in any "other disclosing entity"? This question is asking if any of your owners have an ownership or control interest in any other organization that would qualify as a "disclosing entity." "Other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX or the Act. This includes:

a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
b) Any Medicare intermediary or carrier; and
c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Whereas "disclosing entity" is limited to Medicaid provider, "other disclosing entity" can include entities that are not enrolled in a Medicaid program.

List in the following table the name of each owner of you who has such interest and the name of other disclosing entity in which the owner has an ownership or control interest in:

Table 6:

Name of Owner	Name of Other Disclosing Entity
Aetna Health Holdings, LLC	Aetna Health Inc. (a Pennsylvania Corporation)
Aetna Health Holdings, LLC	Aetna Health of California
Aetna Health Holdings, LLC	Aetna Health Inc. (a Georgia Corporation)
Aetna Health Holdings, LLC	Coventry Health and Life Insurance Company
Aetna Health Holding, LLC	Coventry Health Care of Iowa

Please copy this page if additional space is needed. See attached table for additional information.

Section 5: Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term "managing employees" means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term "managing employees" includes any "agent" of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider's practice locations must be reported in this section.

Please provide the following information in the table below; the name of all managing employees, title, address, DOB, and SSN.

Section 4: Other Disclosing Entities

Table 6:

Name of Owner	Name of Other Disclosing Entity
Aetna Health Holdings, LLC	Coventry Health Care of West Virginia, Inc.
Aetna Health Holdings, LLC	Coventry Health Care of Missouri, Inc.
Aetna Health Holdings, LLC	Coventry Health Care of Kansas, Inc.
Aetna Health Holdings, LLC	Aetna Health Inc. (a New Jersey Corporation)
Aetna Health Holdings, LLC	Aetna Health Inc. (a New York Corporation)
Aetna Health Holdings, LLC	Aetna Health Inc. (a Maine Corporation)
Aetna Health Holdings, LLC	Coventry Health Care of Louisiana, Inc.
Aetna Health Holdings, LLC	HealthAmerica Pennsylvania, Inc.
Aetna Health Holdings, LLC	Aetna Health Inc. (a Texas Corporation)
Aetna Health Holdings, LLC	Coventry Health Care of Texas, Inc.
Aetna Health Holdings, LLC	Coventry Health Care of Georgia, Inc.
Aetna Health Holdings, LLC	Aetna Health Inc. (a Florida Corporation)
Aetna Health Holdings, LLC	HealthAssurance Pennsylvania, Inc.
Aetna Health Holdings, LLC	Aetna Health Inc. (a Connecticut Corporation)
Aetna Health Holdings, LLC	Coventry Health Care of Nebraska, Inc.
Aetna Health Holdings, LLC	Coventry Health Care of Virginia, Inc.
Aetna Health Holdings, LLC	Coventry Health Care of Illinois Inc.
Aetna Health Holdings, LLC	Aetna Better Health, Inc. (an Illinois Corporation)
Aetna Health Holdings, LLC	Aetna Better Health Inc. (an Ohio Corporation)
Aetna Health Holdings, LLC	Aetna Better Health of Michigan, Inc.
Aetna Health Holdings, LLC	Aetna Better Health Inc. (a New Jersey Corporation)
Aetna Health Holdings, LLC	Aetna Better Health Inc. (a Pennsylvania Corporation)
Aetna Health Holdings, LLC	Aetna Better Health, Inc. (a Louisiana Corporation)
Aetna Health Holdings, LLC	Aetna Medicaid Administrators LLC
Aetna Health Holdings, LLC	HealthCare USA of Missouri L.L.C.
Aetna Health Holdings, LLC	Coventry Health Care of Virginia, Inc.

Table 7:

Name	Title	Address	DOB	SSN
Pamela S. Sedmak	Director, CEO and President	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	[redacted]	*
Debra J. Bacon	Director	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	[redacted]	*
Janet R. Grant	Director	10 South Broadway, Ste. 1200 St Louis MO 63102	[redacted]	*
Elaine R. Cofrancesco	Vice President and Treasurer	151 Farmington Ave. Hartford, CT 06156	[redacted]	*
Robert M. Kessler	Vice President	151 Farmington Ave. Hartford, CT 06156	[redacted]	*

* Refer to P.L. 93-579, Disclosure of Social Security Account Number

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Section 6: Final Adverse Actions

This section captures information on "Final Adverse Actions," such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person's involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Table 7:

Name	Title	Address	DOB	SSN
Brian C. Winters	Assistant Controller	304 Jefferson Ct. Collegeville, PA 19426	[redacted]	*
Kevin J. Casey	Senior Investment Officer	151 Farmington Ave. Hartford, CT 06156	[redacted]	*
Steven Conte	Principal Financial Officer & Controller	151 Farmington Ave. Hartford, CT 06156	[redacted]	*

* Refer to P.L. 93-579, Disclosure of Social Security Account Number

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The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person's involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Have you, under any current or former name or business identity, ever had a final adverse action? ☐ Yes or ☒ No

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Table 8:

Organization or Person Name	Final Adverse Action Taken By	Date of Final Adverse Action

Please copy this page if additional space is needed.

Section 7: Patient Protection and Affordable Care Act

Please answer all five questions:

Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider?

The term "affiliation" includes, but is not limited to, relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve:

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

1. For all individuals or entities listed in any of the previous tables, list all that have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa governments or mark none.

   [X] None

Name:

2. For all individuals or entities listed in any of the previous tables, list all that have been or is subject to a payment suspension under a federally-funded health care program or mark none.

   [X] None

Name:

3. For all individuals or entities listed in any of the previous tables that have had its billing privileges denied or revoked or mark none.

   [X] None

Name:

Please copy this page if additional space is needed.

4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

☒ None

Name:

5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

☒ None

Name:

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification of concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Legal Entity Signatory Pamel S. Sedmak	
Signature of Authorized Signatory	Date 5/18/15

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Appendix C

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3.2.8 (Q8) Crisis Plan

Crisis & Safety Planning Session

Crisis and Safety Support Plan SAMPLE

***Crisis and Safety Support Pan For*:** Sample Patient
Prepared By: Sally, Sample, and the Child and Family Team*

Define: (What is a crisis episode for your child and family)
Sally is concerned for the safety of her sons in the home due to Sample's violent outbursts. Sample and his brother have violent fights. Sample was put on probation about a year and a half ago after he assaulted Sam breaking his nose. Last week the fighting escalated. Sample threatened to hit Brother with a baseball bat but instead broke a lamp. Sample stated that he wished he were never born then went to the skate park and got high with some kids**.**

Predict: (When is a crisis episode most likely to occur?)
Sample is most irritable in the mornings after he stays up late playing video games or hanging out with his friends. It is when Sample has to go to school the next morning that most of these fights occur. The fights generally involve sharing clothing, food, or the bathroom or when Sample is stressed because he didn't do his homework or study for exams. If he is unable to de-escalate himself, he clenches his fists until his knuckles turn white. This is followed by violent outbursts. Once Sample becomes aggressive, it is hard to redirect him. At this point it is better to give Sample space. Prior to the incident above, Mom has had some success in redirecting Sample.

Prevent: (What things can be done to stop episodes from occurring? What activities can your child engage in to feel better)?

1. Sample's uncle has agreed to spend one on one time with Sample every other weekend participating in an activity chosen by Sample.
2. Sample will stick to the agreed upon 10pm weekday night bedtime.
3. TVs and gaming stations will be moved to the family room.
4. Clothing sharing decisions will be made the night before school.
5. A structured morning routine will be developed for both Sample and Brother.
6. The therapist will work with Sample on self-awareness skills and self-calming techniques.
7. The school will allow Sample to take a "time out" or go see the counselor if he feels he is losing control.
8. The neighbor has agreed to make his home a neutral place for Sample to go and get ready for school on mornings when Sample is particularly agitated.
9. The neighbor will check-in on Sample and Brother after school on the days Mom works.
10. If Sample starts to raise his voice or swear, Mom will try to redirect Sample twice to go out and ride his skateboard or bike around the block. If Sample does not want to do this, Mom will give him the agreed upon non-verbal signal to leave the room and practice calming techniques.

Response: (What things can be done to help when an episode occurs?)

1. Sample will be given space until his anger episode has worn off. Everyone will leave the room and mom will monitor Sample for safety purposes.
2. Mom will call Uncle and ask him to come over and be present to help calm Sample down.
3. Mom will put on Kottonmouth Kings music for Sample to listen to as this has helped relax him before.
4. Sample's therapist and school counselor will be notified of the event as soon as possible (counselor's phone number and therapist's phone number).
5. County crisis number will be called if Sample threatens to hurt himself (crisis number).[i]

---

* The Child and Family Team (CFT) is a defined group of people that includes, at a minimum, the child and his/her family, a behavioral health representative, and any individuals important in the child's life and who are identified and i invited to participate by the child and family. This may include, for example, teachers, extended family, members, friends, family support partners, healthcare providers, coaches, community resource providers, representatives from churches, synagogues or mosques, agent from other service systems like CPS or DDD, etc. Source: AZ Dept of Health

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Appendix E

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4.3.12.4 Diversion Strategies

Proposed Nursing Facility Diversion and Community Transition Plan (Pages 794 –805)

Diversion and Community Rebalancing Program (Pages 806 –811)

Nursing Facility and Community Rebalancing Program Process Flow (Pages 812)

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Aetna Better Health of Iowa
Long Term Services and Supports
Nursing Facility Diversion and Community Rebalancing Program Description
April 2015

BACKGROUND

Since 1989, Aetna Medicaid has been successful in diverting members from institutional settings and transitioning members from nursing facilities into their own homes with HCBS, or into community-based settings.

Aetna Better Health of Iowa will develop, implement, and maintain a Nursing Facility Diversion and Community Rebalancing (NFD/CR) Program in accordance with the State of Iowa and Medicaid contractual requirements.

PURPOSE

The Nursing Facility Diversion and Community Rebalancing Plan establishes processes to support members who may want to continue residing in a community setting or transition from a nursing facility to the community. The NFD/CR Program/Plan will focus on increasing the percentage of members residing in and remaining in the community. The NFD/CR will not prohibit or delay a member's access to nursing facility services when these services are medically necessary and / or requested by the member.

To achieve the goal of the NFD/CR Program, Aetna Better Health of Iowa utilizes its Integrated Care Management (ICM) Model, experienced LTSS case managers and linkages with its providers and stakeholders. In keeping with the vision of Aetna Better Health of Iowa, LTSS care management is built upon a respect for the member's preferences, interests, needs, culture, language, and belief systems. The entire organization supports the concept that members have a right to determine what is best for them, and our role is to assist them in understanding and facilitating those choices.

NURSING FACILITY DIVERSION AND COMMUNITY REBALANCING PROGRAM OBJECTIVES:

Achieving the objectives of the NFD/CR Program will enable Aetna Better Health of Iowa members to reside in the least restrictive setting that can meet their needs. The program objectives include:

- Providing information and education to members living in nursing homes, regarding the supports and options available to live in community settings.
- Increasing the number of members residing in home and community based settings through NF diversion and relocation of NF residents who request transition to a home and community based setting
- Supporting members in living in cost-effective home and community based settings where appropriate and when aligned with the members' preferences which may also reduce Medicaid costs
- Increasing members' participation in the Community Rebalancing /Money Follows the Person (CR/MFP) demonstration program to enable the state to claim enhanced CR/MFP federal match.
- Identify members whose needs may be met in community based settings rather than being placed in a NF.
- Support member in the community to avoid revisiticism of NF placements for members who have been discharged to the community.

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Aetna Better Health of Iowa
Long Term Services and Supports
Nursing Facility Diversion and Community Rebalancing Program Description
April 2015

SCOPE

Our Facility Diversion process uses established and field-tested processes. It supports all members who want to remain in the community after a change in their condition puts them at risk for a nursing facility placement after hospitalization, admission to a rehabilitation facility, or short-term admission to a nursing facility.

Our Community Rebalancing process is based on the belief that all members who reside in a nursing facility, regardless of the length of residence, have the opportunity and choice to explore their return to the community. We work with all of our program members (both LTSS and non-LTSS) to support their ability to reside in the least restrictive setting and in accordance with their personal preferences. Our NFD/CR does not prohibit or delay a member's access to nursing facility services when those services are medically necessary and requested by the member.

Nursing Facility Diversion

As a part of our NF Diversion and Community Rebalancing Program, Aetna Better Health of Iowa collaborates internally and externally in nursing facility (NF) diversion efforts. These diversion efforts do not prohibit or delay a member's access to nursing facility services when services are medically necessary and requested by the member.

Efforts include but are not limited to:

- Effective and communication among providers and plan
- Appropriate training for plan and providers staff for early identification of members that may be candidates for the nursing home diversion program for referral for diversion services that may prevent members from being prematurely institutionalized
- Regular and ongoing follow up activities to sustain members in community living
- Health Risk assessment screenings

Targeted members for diversion activities include:

- Members awaiting admission to nursing facilities, an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID), or other institutional settings to attempt to provide community supports through HCBS when members choose HCBS
- Members in the community, including those residing in their own homes, and those residing in assisted living facilities, who have a change in circumstances and or deterioration in health or functional status who are requesting nursing facility or ICF/ID services
- Members (including waiver enrollees) who are admitted to a hospital or inpatient rehabilitation facility that do not reside in a nursing facility
- Members placed on a short term basis into a nursing facility regardless of payment sources

Interventions may include educating staff and providers for early identification of members who may benefit from the NF diversion program. This includes educating member services staff, concurrent review, prior authorization and LTSS care management staff. Provider education includes PCPs,

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specialist, advocates, and non-traditional providers. Education may be in the form of provider manuals, newsletters, web portal, information, provider forums, and meetings.

Community Rebalancing / Money Follows the Person

The Community Rebalancing / Money Follows the Person (CR/MFP) Program overlays the Aetna Better Health of Iowa Care Management program very well. Our case manager assessment process allows our case managers to regularly review NF MDS records and utilize valid and reliable assessment tools to identify members who may be appropriate for transition to the community and those that are interested in transitioning to the community from a NF setting. Aetna Better Health of Iowa will assign a case manager Supervisor with the responsibility to be the CR/CR/MFP Liaison. This liaison shall be the primary point of contact between the plan and NFs. This liaison shall work in collaboration with the member's case manager and be responsible to deal with all issues or concerns related to Community Rebalancing and the CR/MFP program.

Case managers will participate in NF interdisciplinary team meeting, assessing transitional service needs and authorizing and procuring assessed transition services. The case manager will also be responsible for identifying potential members for transition along with facilitating the Interdisciplinary Care Team meetings and facilitating and coordinating transition plans with input and guidance from the State of Iowa and the Aetna Better Health of Iowa CR/CR/MFP liaison. The case manager will maintain responsibility for implementing the transition plan to proactively address the discharge needs of all LTSS members and implementing a process to assess members residing in a NF who can safely be transitioned back into the community and have expressed in interested in transitioning to a community setting.

A proactive transition process will be developed and implemented to safely and effectively transition members back into a community setting and decrease the reliance on institutional settings for the provision of LTSS needs. Aetna Better Health of Iowa will develop a network of transitional service suppliers to meet member needs. The transition process will promote member's dignity, choice and autonomy. Prior to the start of the LTSS program Aetna Better Health of Iowa will develop and present a Nursing Facility to Community Rebalancing Plan to the indicated Iowa State Agency for approval. Once approved, we will implement our Nursing Facility to Community Rebalancing Plan. The elements of this plan will include:

1) The Process to identify Members who have the ability and/or desire to transition from a nursing facility to the community including but not be limited to:
   a) Referrals from treating physician, nursing facility, other providers, community-based organizations, family, and self-referrals;
   b) Identification through the LTSS Care Management processes; and
   c) Review and analysis of Minimum Data Set (MDS) data from the nursing facility or State.
2) Mechanism by which the Member's assigned case manager ensures the development of a coordinated and seamless transition plan specifically designed to meet member needs, through engagement of or participation in an Interdisciplinary Team consisting of NF staff, and others providers or authorized representatives and caregivers as appropriate.

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3) Protocol for how the assigned case manager assesses the Member's transitional needs, including the authorization for payment and procurement of transitional services.
4) Mechanisms identifying how Aetna Better Health of Iowa will monitor the effectiveness of the NF to Community Rebalancing Plan including performance measures that include: emergency room visits, hospitalizations, re-hospitalizations, re-institutionalizations and other quality measures as required by the state to meet federal reporting requirements of the CR/MFP demonstration.
5) Overview of the quality assurance and performance improvement strategies utilized by Aetna Better Health of Iowa to address identified trends in member outcomes for individuals who have transitioned from a NF to community.

The Transition Plan will further outline Aetna Better Health of Iowa Care Management Responsibilities which will include:

1) Development of a written policy and procedure for identifying enrollees who may be appropriate for Community Rebalancing including those who may qualify for transition under the CR/MFP demonstration program from an institutional setting back into the community.
2) Referring potential Community Rebalancing and/or MFP candidates to the correct appropriate CR/MFP Liaison to oversee the transitional process.
3) Active participation in the NF Interdisciplinary Care Team meetings to develop a member centric Community Rebalancing plan
4) Coordination with the Member, family, NF staff and CR/MFP Liaison, as appropriate, in the identification, approval and purchasing of the necessary Transition Services
5) Coordination with the member, family, NF staff and CR/MFP Liaison to coordinate a plan of care including authorization of services to begin upon discharge

All members identified as potential transition candidates to the CR/MFP program shall be documented in the LTSS care management electronic case record and will receive the required transition counseling. Upon completion of transition counseling, the case manager shall submit the CR/MFP eligibility form to the appropriate regional CR/MFP liaison. Once approved by the CR/MFP Program, the case manager will participate in all Interdisciplinary Care Team meetings and other communications necessary to ensure the member's seamless transition to the community. The ICT will include any target case managers that may have already been involved in the member's care. The case manager will work with the CR/MFP Liaison and IDT to identify, approve, and authorize all transition services prior to the member's discharge from the facility.

Prior to the transition, the case manager will conduct a full assessment of the member's needs, using the InterRAI / SIS tool and will work collaboratively with the member to create an agreed upon community based plan of care, which the member will sign, prior to the member's date of discharge. Once the member is discharged, the case manager will outreach the member within five (5) business days of discharge and conduct a face-to-face visit in the community placement within ten (10) business days of the discharge. The plan of care will be revised as necessary to meet the member's needs.

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At a minimum, the case manager will complete monthly telephonic outreach and quarterly face-to-face visits for 365 days from the date of discharge. Aetna Better Health of Iowa will track all CR/MFP qualified days for CR/MFP participants and notify the CR/MFP Liaison of any triggers that would stop the CR/MFP clock or disqualify a member from the program. Once a member is successfully transitioned, standard care management processes will continue as will the IDT to ensure members continued needs are met.

RESPONSIBILITIES

The Aetna Better Health of Iowa NF Diversion and Community Rebalancing Program is managed by experienced team of case management staff working under the direction of Director of Medical Management/director of Long-Term Services and Supports (LTSS) and the chief medical officer (CMO).

The responsibilities of the NF Diversion and Community Rebalancing team include:

- Developing and providing training to health plan staff on the early identification of members who may be candidates for nursing home diversion program and for referral for diversion services that may prevent them from being institutionalized
- Identifying and evaluating the Plan's alternative care options (e.g. skilled home care, Physical Therapy, Occupational Therapy, Speech Therapy, residential modifications, and explore participant direction options with member.
- Collaborating with Aetna Better Health of Iowa community outreach and education resources to enable them to provide communication on the availability of the program
- Providing resources for staff and members on available housing, and when requested, meaningful employment.
- Acting as a subject matter expert (SME) for health plan staff
- Providing consultation and support for staff, the members, and caregivers as appropriate.
- Coordinating NF Diversion activities with related Aetna Better Health of Iowa initiatives such as the preventable readmission reduction program to leverage resources and optimize the members' outcomes.
- Tracking Aetna Better Health of Iowa members enrolled in the NF Diversion Program, including inpatient facility admissions/ readmissions, Emergency Department visits, and member participation in the CR/MFP program
- Monitoring the effectiveness of the NF Diversion Program at the member and program levels

Responsibilities for Case Managers assigned to members that may be appropriate for diversion or relocation include:

- Identifying alternative care options appropriate for his/her assigned members, including exploring participant directed options with member.
- Confirming that services are coordinated for members including those with special needs as well with other Medical Management/Behavioral Health Case Management departments, vendors, and the member's primary care practitioner (PCP) as appropriate
    - Conducting Face to Face assessments andr reassessments
    - Convening an ICT meeting to discuss service options and transitional needs such as home visits, furniture, food, deposits, etc.

PROPOSED

- Coordinating with the Interdisciplinary Team (ICT) to identify services that will support the member in the least restrictive environment possible, in accordance with the member's wishes.
- Coordinating members' services and ensureing the services are adequately meeting member needs.
- Executing a Participant Risk Agreement to include provisions to safeguard a member's health and safety if necessary.
- Documenting, reviewing, and revising a member's Individualized Care Plan as needs are identified.
- Coordinating follow-up activities to sustain members in community living.

ORGANIZATION

Collaborative Entities:

The NF Diversion and Community Rebalancing Program includes input and collaboration from the following internal committees, departments and positions:

Quality Management Committee	Quality Management Division	Learning and Performance
Prevention/ Wellness Committee	Utilization Management Division	Corporate Compliance
Member Advisory Council	Network Development	Business Continuity and Emergency Services
Interdisciplinary Care Teams	Member Services Department	CR/MFP Liaison
Chief Operating Officer	Corporate Pharmacist	Participant Directed Liaison
Medical Director	Contracting Department	Legal Services
Behavioral Health Medical Director	Concurrent Review	Medical Management
LTSS Care Management Dept.	Behavioral Health Department	Integrated Care Management

The NF Diversion and Community Rebalancing Program works very closely with the medical director and behavioral health medical director at the plan. Case managers have immediate access to a medical director that primarily supports the LTSS Program. Case managers may review any case with the medical director after discussing the case with their supervisor.

LTSS NFD/CR Program Staff

The Director of LTSS oversees the NF Diversion and Community Rebalancing Program and is accountable to the chief medical officer (CMO) of Aetna Better Health of Iowa. The manager is supported by an accomplished team which includes the Manager of LTSS, LTSS Supervisors, including the CR/MFP Liaison and a Consumer Directed Services Liaison. The team also includes a behavioral health administrator and trained and skilled case managers. Care management Associates assist the case managers and supervisors with non-clinical tasks.

PROPOSED

The LTSS Care Management unit will have case managers with expertise in the areas of housing, education and employment issues. These case managers will have local community knowledge about other resources available in the Contractor's service area and will assist other case managers and their supervisors with up-to-date information designed to help members make informed decisions about their independent living options.

The care management unit resides within Aetna Better Health of Iowa's LTSS Care Management Department. The care management unit has been structured with the following hierarchy: (Please also refer to LTSS Organizational Chart).

Manager of Long Term Services and Supports

The Manager of Long Term Services and Supports is responsible for the development, implementation, oversight, and evaluation of the Care Management Program. The LTSS manager is responsible for complying with DHS mandated care management requirements and approved caseload ratios. The Manager is also responsible for supervising the LTSS care management supervisors and establishing systems for tracking their performance. The LTSS Manager oversees the CR/MFP and Participant Directed Services Programs.

Care Management Supervisors

The LTSS Care Management supervisors play a major role in assuring the success of the Care Management program. They are responsible for the day-to-day supervision of the case managers and backup coverage for all case managers. The supervisors handle all administrative functions related to the case managers, including performance monitoring, employee professional development, inter-rater reliability and evaluations.

The LTSS Care Management supervisors will be either Iowa licensed registered nurses or degreed social worker/health care professionals. As a program, we hire the best-qualified individuals and provide a career ladder for our LTSS case managers. In the recruitment and screening process our ideal candidate would be an individual whose care management experience is in the LTSS programs that provide exposure to both the community and facility based populations along with some supervisory experience.

Supervisors are also utilized to assist case managers with specialized programs. Examples of this are the supervisors who serve as the liaisons for the MFD/CT and Money Follows the Person program and Consumer Directed Care Program Supervisors with these responsibilities provide guidance to case managers and serve as the conduit for our members who could benefit from these specialized programs.

Case Managers

The case managers are licensed registered nurses, licensed behavioral health professionals and individuals who are either degreed in the Human Services or related field with the Iowa required LTSS care management experience. Case managers do not provide direct care services to members, but assess, reassess and authorize appropriate services and refer members to services. The role of the case

PROPOSED

manager is to collaborate with members and/or families in assessing, educating, facilitating, planning, advocating, and addressing the member's individual needs. Their role may vary depending on caseload setting, cultural needs, economic situations, and member's individual needs.

Case managers comply with all aspects of the NFD/CR Program. The broad roles and responsibilities of the case managers are as follows:

- Assessing member's medical, functional, and social needs,
- Creating individualized care / service plans, collaborating with member/family to develop a plan that enhances outcomes and promotes independence
- Implementing, facilitating, and coordinate services:
- Monitoring, evaluating and modifying services as needed to achieve desired outcomes:
- Providing conflict free care management services

CARE MANAGEMENT ACTIVITIES SUPPORTING THE NFD/CR PROGRAM

Interdisciplinary Care Team Meetings

All LTSS members are invited to participate in interdisciplinary care team meeting, with participants chosen specifically by them. Interdisciplinary Care Team meetings can be instrumental in efforts to manage challenging behaviors, frequent emergency room visits or hospitalizations, or other complex cases including those that are over the cost threshold for HCBS or have significant risk in their HCBS placement. The interdisciplinary care teams always include the member and case manager, case manager supervisor, and when appropriate also include LTSS member representative, behavioral health administrator a medical director, behavioral health medical director, clinical pharmacist, concurrent review manager, RN nurse manager, RN nurse supervisor, target case manager, or other providers or DHS representatives that may assist in the member care. Strategies for reducing the frequency of hospital admissions for members with multiple admissions are discussed, as well as strategies for maintaining the member safely in the most integrated setting. Interventions may include an increase in LTSS such as home health nursing, referral to behavioral health services, review of medications by a pharmacist, referral to hospice services, recommendation for a change of placement setting, referral to the specific programs or letters/phone calls from the Plan Chief Medical Officer to the medical providers involved in the member's care.

Advance Directives

Aetna Better Health of Iowa case managers have been trained on advance directives, the impact they can have on a person's life and program requirements for advance directives data collection. Advanced Directive trainings are provided to case managers by Aetna Learning and Performance, community agencies, and Plan Management.

To meet contract requirements, case managers routinely bring copies of advance directive forms to their members' homes and provide continuing education to the members and their families about the importance of having these documents completed. At each review, case managers continue to encourage the member/family to determine their preference for advanced directives and to complete the paperwork indicating their choices. Copies of completed advance directives are kept in the

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electronic LTSS care management record, the PCP record and with the Compliance Department. Completion dates for advanced directives are recorded and tracked in the LTSS care management electronic medical record. Plan supervisors can run reports out of the electronic LTSS care management system at any time to check case manager progress in obtaining advanced directives. Monthly reports are run by the LTSS Care Management Department to track the overall percentage of members with completed advance directives.

Disaster Emergency Planning

As a part of each assessment/reassessment process, the case manager will work with the member/member supports to identify emergency contacts, and share with the member/member supports the importance of developing an emergency plan for the household. This may include evacuation planning with detailed information added to the member's case file about where the member will go, who will transport the member and how to reach the member at the alternate location. The member/member supports will have information about how to contact a case manager or nurse if our office is damaged and our local phone lines are not in service. In addition, the case manager will share information from the Federal Emergency Management Agency's website at www.fema.gov and the State office of Emergency Management. The case manager will educate the member on the Emergency Response kit. At a minimum it should include:

- Three day supply of canned food
- Three day supply of water (3 gallons per household member)
- Battery operated radio and extra batteries
- Flashlight with extra batteries
- One week's prescription medications
- First aid kit
- Personal toiletries
- Non-electric can opener and utensils
- Special needs items for the member i.e.- incontinence supplies, oxygen, other supplies
- Cash or travelers checks
- Important documents – include the case manager's contact information, physician information

In the event of a natural disaster such as a tornado, as soon as it is safe to do so, home-bound members whom we are not able to contact by phone will be visited to assure that they are safe and receiving needed care. We will collaborate with the all service providers in this effort.

DOCUMENTATION and CASE FILE STANDARDS

Case managers are required to adhere to established case file standards for all members involved in the NF Diversion/Community Rebalancing program. Aetna Better Health of Iowa uses an electronic LTSS care management software package, to support its LTSS care management documentation activities and program operations. This system enables case managers to track demographic and placement information, assessments/reassessment completion and timelines, document member visit and interactions and activities, monitor compliance, , and provide detailed reports on placement, transition services, and cost information.

PROPOSED

The electronic case file is able to store linked documents pertinent to each member's case. Linked documents include:

- Assessments/Reassessments
- Referrals for CR/MFP and Community Rebalancing services
- Copies of Risk agreements
- Copies of signed Plans of Care / Services Plans
- Copies of HCBS Needs Assessment Tools
- Copies of Backup/Contingency Plans
- Copies of any tools used to document member's needs
- Room and Board Agreement, Single Occupancy Agreement, and SSI Repayment Agreement
- Copies of Advance Directives
- Cost effectiveness Studies
- Gaps in Care and Services
- Critical Incidents
- Evidence of supervisory review

LTSS COMMUNITY REBALANCING PROGRAM AND COMMUNITY INVOLVEMENT

The Aetna Better Health of Iowa NFD/CR team and individual case managers are encouraged to be involved in and forge partnerships with community agencies that benefit our members and support Community Rebalancing efforts. This includes but is not limited to external entities such as:

Support Brokers	Fiscal Employment Agencies	Ombudsman/Adult Protective Services
Accredited training agencies	HCBS Providers	Department of Health Services
AAA/Aging & Disability Resource Centers	Utility Community Assistance organizations	County based emergency preparedness groups
Consumer advocacy groups	Local law enforcement LTSS Advocates	Nursing Facility Associations and Providers

NFD/CR PROGRAM MONITORING

Care Management Program Oversight
Aetna Better Health's Director of Long Term Services and Supports (LTSS) and the Chief Medical Officer will be responsible for oversight of our LTSS care management activities, including, but not limited to, the design, implementation, management, direction, and execution of our NF Diversion and Community Rebalancing Program. Results from this monitoring are used to support our continuous process improvement strategy which addresses identified inconsistencies or deficiencies and is documented, trended, reviewed in team and relevant quality committee meetings and included in annual NF Diversion and Community Rebalancing Program evaluations.

MEASUREMENT / REPORTING
Internal Reporting

PROPOSED

The effectiveness of the NFD/CR Program will be monitored using specific metrics. Monthly reports will be generated and reviewed by Medical Management leadership to monitor the effectiveness of the NFD/CR Program.

The effectiveness of efforts to keep members remaining in the community are reflected in the following metrics and monitoring:

- Member outcomes (e.g., fewer transitions to nursing facility from the community)
- Monthly readmission reports
- ICT Meeting outcomes

The effectiveness of Transitions from a Nursing Facility to Community Based Setting are monitored through:

- CR/MFP referral and process tracking, including
  - qualified transitions for those under age 65 and those 65 or older
  - members who qualified but did not transition to the community, including the reason why the transition did not occur
- Service utilization of program members
- Critical Incident Reports
- Readmission tracking through Concurrent Review, Case Management, and Behavioral Health Care Management; for skilled nursing provider (SNP) members for hospital and long-term care admissions within one (1) business day of admission.
- Data are analyzed at least quarterly, to identify individual members at risk of being institutionalized including those with special needs. Aetna Better Health of Iowa minimizes unplanned transitions and strives to maintain members in the least restrictive setting possible by coordinating services for members at high risk of having a transition and educating members or responsible parties about transitions and how to prevent unplanned transitions.

State Specific Reporting

All CR/MFP required reports will be submitted as prescribed by the state. Should the state identify any additional quality and/or outcome measures as required by the CR/MFP Operational protocol, the plan will due diligence to implement those as well.
As required, Aetna Better Health of Iowa will participate with the state to allow them access to data to comply with required reports to the State.

AETNA BETTER HEALTH OF IOWA NURSING FACILITY DIVERSION AND COMMUNITY REBALANCING PLAN/PROGRAM DESCRIPTION ANNUAL REVIEW

Annually at a minimum, the NF Diversion and Community Rebalancing Plan/Program description is reviewed by the LTSS care management team and the Quality Management Committee [aka: Quality Management Oversight Committee (QMOC)] to identify progress towards goals, lessons learned, opportunities for improvement, and strategies to implement process improvement. This program description will be reviewed at the Quality Committee for approval. Once approved, the Plan will be submitted annually to the office of Quality Assurance within DHS in accordance with contract standards.

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Aetna Better Health of Iowa
Long Term Services and Supports
Nursing Facility Diversion and Community Rebalancing Program Description
April 2015

SUPPORTING DOCUMENTS

Policy: Policy #7800.34 – Nursing Facility Diversion and Community Rebalancing Program

Process Flow: Nursing Facility Diversion and Community Rebalancing Process

PROPOSED

Policy

Policy Name:	NF Diversion and Community Rebalancing Program	Page:	X of X
Department:	Medical Management	Policy Number:	7800.34
Subsection:	Integrated Long-Term Care Management	Effective Date:	01/01/2016
Applies to:	■ Medicaid Health Plans ■ Medicare-Medicaid Health Plans		

PURPOSE:

The purpose of this policy is to provide structure for [PLAN's] Nursing Facility (NF) Diversion and Community Rebalancing (NFD/CR) program. The program will focus on increasing the percentage of members residing in and remaining in the community. The NFD/CR Program will not prohibit or delay a member's access to nursing facility services when these services are medically necessary and / or requested by the member.

STATEMENT OF OBJECTIVE:

Achieving the objectives of the NFD/CR Program will enable [PLAN] members to reside in the least restrictive setting that will meet their needs. Successful NF diversion programs:

- Provide information and education to members living in nursing homes about the supports and options available to live in community settings
- Increase the number of members residing in home and community based settings through NF diversion and relocation of NF residents who request movement to a home and community based setting
- Support members in living in more cost-effective home and community based settings where appropriate and aligned with the members' preferences to reduce Medicaid costs
- Increase members' participation in the Money Follows the Person (MFP) demonstration program to enable the state to claim enhanced MFP federal match

DEFINITIONS:

Balancing Incentive Program (BIP)	Program is to rebalance expenditures towards community-based long term supports services such that they are equal to or great than facility-based expenditures.
Case Management Coordinators (CMC)	Case management coordinators (CMCs) are staff members who are experienced in health and/or social services, but are not licensed clinicians. They coordinate designated components of health care, such as LTSS services, appropriate referral to consultants, specialist, hospitals, ancillary providers and other necessary services.
Clinical Case Manager (CCM)	Clinical case managers (CCMs) lead the collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-

	effective outcomes. They provide education on the impacts of conditions and psychosocial variables as well as how to use available services effectively. CCMs must be qualified to perform clinical assessments (i.e., a registered nurse or behavioral health clinician licensed to practice independently) and develop service plans based on the member's unique health and service needs.
Conflict-Free Case Management (CFCM)	CMS defines conflict-free case management as having the following aspects: Clinical or non-financial eligibility determination is separated from direct service provision.
Diversion	To provide early outreach and appropriate interventions to members admitted to rehabilitation or skilled nursing facilities help them avoid long term NF stays *(definition resource: ADRC)*
Home and Community Based Services (HCBS)	HCBS are a variety of service choices that can be provided in a member's home and community (e.g., adult day health, residential care facilities) so a member can stay independent and close to family and friends. These services include but are not limited to: attendant care, homemaker, personal care, home delivered meals, adult day care, emergency response system, home health nursing and self- directed care.
Hospital post-discharge planning	Hospital post-discharge planning is the utilization management function that is concerned with coordinating or arranging for post-hospital care or clinical needs in order to facilitate timely discharge from the hospital and prevent readmissions.
Interdisciplinary Team (ICT)	An interdisciplinary care team is led by the case manager and is composed of the member, a member's health care and service providers that may include, but are not limited to, the primary care physician, specialists, home and community based service (HCBS) providers, the member's family and/or representative. The ICT may also include [PLAN] staff such as the medical directors, behavioral health specialists, pharmacist, utilization and care management, or other appropriate health plan staff. This team works together to coordinate the delivery of services for the member.
Nursing Facility (NF) Diversion Program	Program designed to allow members to remain in or return to the least restrictive setting in which they may safely reside through provision of HCBS.

Plan of Care	This is the current MM/QM Definition for Plan of Care: A written description in the care management record of member-specific health care goals to be achieved and the amount, duration, and scope of the covered services to be provided to a member in order to achieve such goals. The individual plan of care is based on assessment of the member's health care needs and developed in consultation with the member and his/her informal supports.
Practitioner	A licensed or certified professional who provides medical or behavioral healthcare services.
Preventable Readmission Reduction Program	Program supporting a successful discharge from the hospital by addressing the discharge needs of members who are at-risk for re-hospitalizations. Program aids in allowing members to remain in the community with the appropriate services and supports. The readmission reduction interventions are designed to address the need of the member and coordination of care across multiple settings and practitioners.
Relocation	To assist members residing in NFs who wish to relocate to a home and community based setting.

LEGAL/CONTRACT REFERENCE:

- Applicable federal and state laws, regulations, and directives, including those regarding the confidentiality of member information (e.g., Health Insurance Portability and Accountability Act [HIPAA])
- Applicable accreditation agencies, clients, administrative authorities
- Iowa Administrative Code 441, Chapter 77

FOCUS/DISPOSITION:

[PLAN]'s care management staff and members collaborate to develop, implement, and monitor a comprehensive individualized plan of care, addressing all areas identified in the Needs Assessment. The plan of care targets the identification of physical, emotional and social needs that must be met for the member to remain safely in the community. Once the needs are identified, the plan of care cites strategies, specific interventions, and identifies the supports and services approved to mitigate risks and support successful residence in non-custodial settings. The effectiveness of these actions will be demonstrated by a reduction in nursing facility admissions from the community and an increased number

of members who wish to reside in home and community settings. To support the transition and maintain continuity of care, the case manager conducts intensive follow up with the member, including increased face to face contact, comprehensive post-transition services intended to meet the member identified care needs, a specific back-up / contingency plan for use should a gap in service occur.

Responsibilities

The [PLAN] NFD/CR Program is managed by an experienced team of care management staff working under the direction of the director of Medical Management/director of Long-Term Services and Supports (LTSS)] and the chief medical officer (CMO).

The responsibilities of the NFD/CR team include:

- Developing and providing training to health plan staff on the early identification of members who may be candidates for the nursing home diversion program and for referral to diversion services that may prevent them from being institutionalized
- Identifying and evaluating the Plan's alternative care options (e.g. skilled home care, Physical Therapy, Occupational Therapy, Speech Therapy, residential modifications, and explore participant direction options with member
- Collaborating with [PLAN] community outreach and education resources to enable them to provide communication on the availability of the program
- Providing resources for staff and members on available housing and meaningful employment
- Acting as a subject matter expert (SME) for health plan staff
- Providing consultation and support for staff, members, and caregivers as appropriate
- Coordinating NF Diversion activities with related [PLAN] initiatives such as the preventable readmission reduction program to leverage resources and optimize the members' outcomes
- Tracking [PLAN] members enrolled in the NFD/CR Program, including inpatient facility admissions / readmissions, emergency department visits, and member participation in the MFP program
- Monitoring the effectiveness of the NFD/CR Program at the member and program levels

Responsibilities for case managers assigned to members that may be appropriate for diversion or relocation include:

- Identifying alternative care options appropriate for his/her assigned members, including exploring participant directed options with member
- Confirming that services are coordinated for members including those with special needs, as well as with other Medical Management/Behavioral Health Case Management departments, vendors, and the member's primary care practitioner (PCP) as appropriate
- Conducting face to face assessments or reassessments

- Convening an ICT meeting to discuss service options and transitional needs such as home visits, furniture, food, deposits, etc.
- Coordinating with the ICT to identify services that will support the member in the least restrictive environment possible, in accordance with the member's wishes
- Coordinating members' services
- Executing a Member Risk Agreement to include provisions to safeguard a member's health and safety if necessary
- Documenting, reviewing, and revising a member's Individualized Care Plan as needs are identified
- Coordinating follow-up activities to sustain members in community living

OPERATING PROTOCOL:

Systems

- The business application system for care management and utilization management

Measurement

- Effectiveness of the members remaining in the community as reflected in the following situations:
  - Member outcomes (e.g., fewer transitions to nursing facility from the community)
  - Monthly readmission reports
  - ICT Meeting outcomes

Analyze data at least quarterly, to identify individual members at risk of being institutionalized including those with special needs.[1] [PLAN] minimizes unplanned transitions and strives to maintain members in the least restrictive setting possible by coordinating services for members at high risk of having a transition and educating members or responsible parties about transitions and how to prevent unplanned transitions.[2]

Reporting

- MFP tracking through NFD/CR team
- Critical Incident Reports

[1] Special Needs Program 4: Care Transitions, Element E
[2] Special Needs Program 4: Care Transitions, Element F

- Readmission tracking through Concurrent Review, Case Management, and Behavioral Health Care Management; for skilled nursing provider (SNP) members for hospital and long-term care admissions within one (1) business day of admission.[3]

INTER-/INTRADEPENDENCIES:

Internal

- Information Technology
- Medical Management
- Quality Management

External

- Ancillary providers
- Applicable vendors
- Community resources
- Facility/hospital departments
- Member and/or member family/caregiver
- State approved waiver service providers
- State Medicaid agency
- Treating practitioners (PCP)

[PLAN]

INSERT NAME Chief Executive Officer	INSERT NAME Chief Medical Officer

[3] Special Needs Program 4: Care Transitions, Element D

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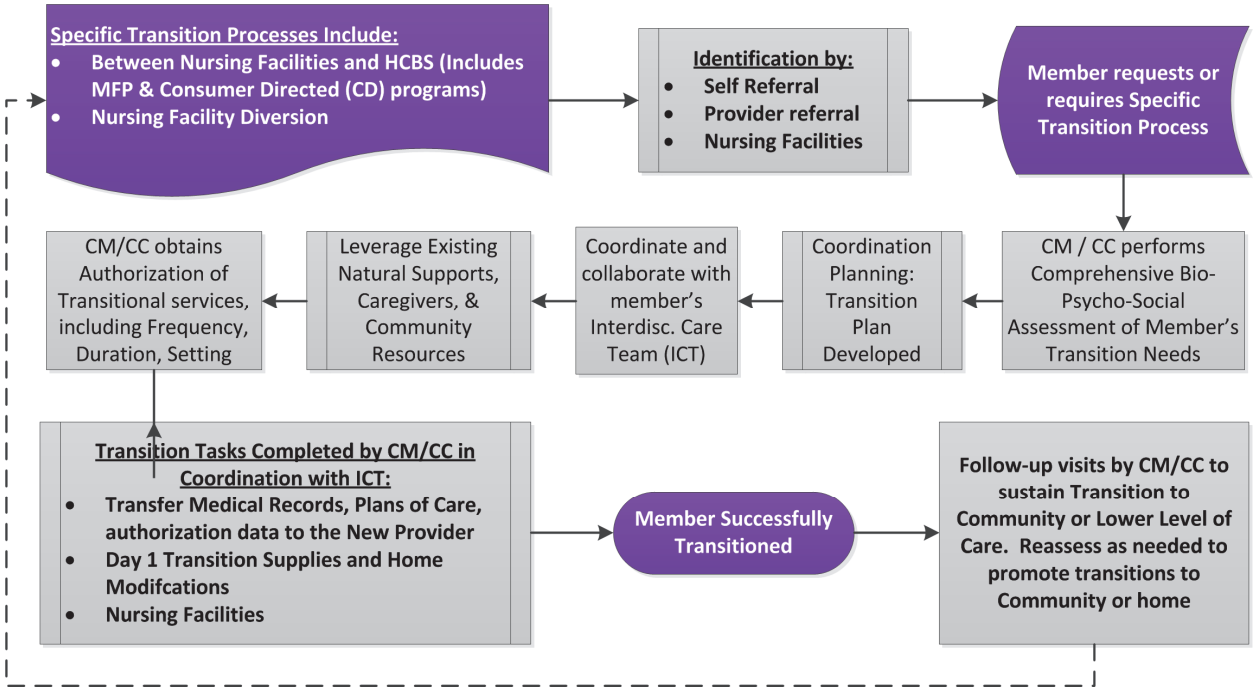
Nursing Facility and Community Rebalancing Program Process Flow



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Appendix F

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4.4 (Q2) Service Plan

AETNA BETTER HEALTH® aetna℠

March 1, 2015
Mr. Sample Name
00 Sample Street
Des Moines, IA 50316

Care Plan for: Sample Name
Member ID #: 111111111

Dear [Name},

Thank you for talking with us today. This **Plan of Care/Service Plan** is a summary of our discussion. Please use this letter to keep track of what we talked about.

Together we set the following goals:

- Sample member and/or his caregiver will have someone who can help with health care needs. By 4/1/2015
- Sample member will have an improved comfort level By 4/1/2015
- Address Sample member's current service coordination needs. Completed
- Sample member will learn ways to manage his condition one step at a time. By 4/1/2015

To accomplish these goals, we agreed to these actions:

What we will do?	Who will do?	By when?	Completed?
Work together to create a plan to support your desire to stay in your home.	Sample member, Case Manager	3/15/2015	In progress
Follow your plan to reduce symptoms of your disease, and distressing feelings about your symptoms. These include: • Use oxygen when you are short of breath, • Take prescribed medication as ordered by your doctor • Rest when you need to, and • See your Integrated Health home team. Case manager and Target case manager will work together with you to meet your needs	Sample member, Case Manager, provider, Target case manager, Mary Sample, Behavioral Health provider	3/15/2015	In progress
Obtain medical treatment for your shortness of breath. This will include extra oxygen you can use when you need to.	Sample member, Case Manager, Provider	3/15/2015	In progress
Call, contact or refer to agency or community resources to get help as needed - Make referral to Morning Star for Jane	Case Manager	3/6/2015	Yes

Sample

Doe to provide self-directed care.			
Call, contact or refer to agency or community resources to get help as needed - 24 Seven Home Care referral for home care attendant while waiting for self-directed care paperwork to be processed.	Case manager	3/6/2015	Yes

We will review this **Plan of Care/Service Plan** on or before 3/15/2015 and will update it as needed.

We also talked about the services you need. Those services are listed below in this letter.

Service Plan

Member's Name Sample Name		**Member ID#** 111111111	**Date** March 1, 2015		
Service & Provider	**Service Frequency in place prior to this assessment**	**Service Frequency currently assessed**	**Service Change**	**Start/End Date**	**Member / Rep**
Personal Emergency Alert System (PERS) by *Med Alert 1*	In place prior to joining Aetna Better Health	Ongoing service with monthly charge.	New	3/01/2015 to 5/31/2015	Agrees
Home Care Attendant Services-Personal Care *by 24 Seven Home Health Care*	New	15 hours per week (5 hours every Tuesday, Thursday and Saturday)	New	3/01/2015 to 5/31/2015	Agrees
Adult Day Care services *by Best Day Care Ever*	New	3 days per week (every Monday, Wednesday, and Friday)	New	3/01/2015 to 5/31/2015	Agrees

Comments Mr. Sample member and Case manager put this plan together during a home visit. Mr. Sample member also set up his backup plan. This plan has information on what to do if his home services don't happen.

Sample

Case manager will call Mr. Sample member every month to review this plan. Mr. Sample member will call Case manager if his needs change. She will visit him in his home at least every 3 months. More visits may be made if Mr. Sample member's needs change.

Plan of Care Acknowledgement: My **Plan of Care/Service Plan** has been reviewed with me by my case manager. I know what services I will be getting and how often. All changes in the services I was getting have been explained to me. I have marked my agreement and/or disagreement with each service above. I know that any reductions, terminations or suspensions (stopping for a set time frame) of my current services will begin no earlier than 10 days from the date of this plan. I know that I can ask for this to be sooner. I know my service plan can change if my condition changes. I know my service plan can change after further review.

If I do not agree with some or all of the services that have been authorized in this plan, I have noted that above. I know that my case manager will send me a letter that tells me why the service(s) I asked for was denied, reduced, suspended or terminated.

That letter will tell me how to appeal the decision that has been made about my services. The letter will also tell me how I can receive continued services.

My case manager has told me how the appeal process works. I know how I can appeal service changes I do not agree with. I know that I can change my mind later about services I agree with today. I know that if I change my mind before the changes go into effect, I will get a letter that tells me the reason my services changed. The letter will also tell me about my appeal rights, including how to receive continued services.

I know that if I need more or other services that I am getting, I can contact my case manager at <<local phone number>>. My case manager will call me within 3 business days. Once I have talked with my case manager, s/he will give me a decision about that request within 14 calendar days. If the case manager is not able to make a decision about my request within 14 calendar days, s/he will send me a letter to let me know more time is needed to make a decision.

Sample Member 3/1/2015

Member Signature | Date

Case Manager 3/1/2015

Case Manager Signature | Date

Sample

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Appendix G

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4.4 (Q6) Sample Consumer Choices Option
(Pages 817)

Consumer Choice Option (CCO) Self-Assessment
(Page 818)

Home and Community-Based Services
Consumer Choices Option
Informed Consent and Risk Agreement
(Pages 819 – 820)

Consumer Choice Option (CCO) Self-Assessment

I, _____, am completing this form to see if I am able to complete the duties of an employer in the CCO program.

Please write yes or no on the line next to each question.

_____1. I am able to interview, hire, train, and supervise employees. I am able to fire employees if needed.

_____2. I am able to create a list of job duties and a work schedule for my employee(s).

_____3. I am able to ensure that I do not spend more money than what is in my budget.

_____4. I am able to work with my Supports Broker to develop my budget.

_____5. I am able to ensure that my employee(s) timesheets are correct. I am able to ensure that receipts for purchases are kept in a way that I can show my budget was used correctly.

_____6. I am able to develop a Back-up Plan so I will know what to do if my employee(s) does/do not show up to provide my services.

_____7. I am able to tell my case manager if I'm having problems with my employee(s).

_____8. I am able to know when I need to change my services or employee(s) providing those services. I am able to know if I should stop using the CCO and instead use an agency for services.

_____9. I am able to understand that it may be a crime to falsely say how I spent my budget. This may result in legal action against me. I am able to understand that it may be a crime to submit time cards with false information. This may result in legal action against me.

_____10. I am able to understand that using my budget for services and purchases that are not part of my Plan of Care may result in being transferred off the CCO program. If this occurs, I understand my needs will be met through traditional agency-based services.

I/my representative can comply with all the above. Do you want to assign a representative to take on the responsibilities of the employer (answer yes or no)_____.

_____

Participant Printed Name | Signature | Date

_____

Representative Printed Name (if applicable) | Signature | Date

Home- and Community-Based Services
Consumer Choices Option

Informed Consent and Risk Agreement

I, _____, choose to participate in the Consumer Choices Option.

I understand that my participation in the Consumer Choices Option is completely voluntary. If I decide that the Consumer Choices Option is not right for me, I understand that I may withdraw from the Consumer Choices Option and receive the services for which I am eligible for under the traditional home- and community-based waiver services. I will not be penalized in any way. I will not lose any benefits to which I am entitled and I will not have to be placed on a waiting list.

_____
(Initial to show you have read and understood the above information.)

I will receive a monthly budget in the amount $_____ to buy services and make other purchases related to my long-term care needs. I understand that I will choose personal care services, community and employment supports and services, and other goods and services that will best meet my needs and are cost effective. I understand that there is an approved list of services and supports that I may purchase from and if I choose a service or support not on the approved list, I will have to seek approval from the Iowa Medicaid Enterprise before purchasing. I understand that I will choose who provides my services, they do not need to be a Medicaid provider, and I will be the employer of record for employees I hire. I understand that by hiring my own employees I accept the risk associated with being an employer. I understand that I will be required to work with an independent support broker of my choosing. I will develop an individual budget with my independent support broker.

I understand that I will also be required to work with a Financial Management Services provider that will be responsible for issuing payment to my employees and for my purchases from my individual budget funds. I understand that if I overspend my budget and no longer have funds in my Individual budget, I am personally responsible to pay my employees and to pay for my purchases. I understand that I am legally required to pay employer-related taxes for the employees I hire. My individual budget must be used to pay for the employer-related taxes. My individual budget must be used to pay for the Financial Management Services fees and the independent support broker's fees. The Financial Management Services will pay for the employer-related taxes, the Financial Management Service fees and independent support broker fees from my individual budget on my behalf.

I will get help from my independent support broker in making sure the budget is being used correctly. I understand that if I misuse my individual budget, I may be transferred back to the traditional home-and community-based Medicaid services for which I am eligible. I understand that I cannot purchase room and board, childcare, and personal entertainment items with my budget.

_____
(Initial to show you have read and understood the above information.)

I understand that I will be responsible for signing all my employees' time cards and by doing so I am verifying that my employees did work the hours claimed on the time card to provide services for me. I understand that signing an employee time card which contains false information about hours worked, may make me a party to Medicaid fraud and legal action could occur.

_____
(Initial to show you have read and understood the above information.)

I have read and understood this consent form. I understand that I get to keep a copy of this consent form.

_____ _____
Consumer's Signature Date Signed

_____ _____
If applicable, Guardian's Signature Date Signed

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Appendix H

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8.2 (Q5) Sample Enrollment Material

Table of Contents
(Pages 822 – 824)

Iowa Handbook
(Pages 825 – 828)

Notice of Privacy Practices
(Pages 829 – 831)

Iowa ID Card Mockup
(Pages 832)

Iowa Mockup Welcome Letter
(Pages 833 – 834)

TABLE OF CONTENTS

COMMON CONTACT INFORMATION x

WELCOME x
- Your member handbook x
- Member Services x
- 24-hour nurse line x
- Language services x
- Other ways to get information x
- Website x

IDENTIFICATION CARD x

ELIGIBILITY AND ENROLLMENT x
- Information about Iowa Medicaid, Iowa Health and Wellness Plan and hawk-i Programs x
- Confirmation of enrollment x
- Changing health plans x
- Enrollment broker x
- Reinstatement x

MEMBER CONFIDENTIALITY AND PRIVACY x

YOUR PROTECTION, RIGHTS AND RESPONSIBILITIES x
- Member advocate services x
- Ombudsman x

GETTING CARE x
- Provider directory x
- Completing a health risk assessment x

YOUR PRIMARY CARE PROVIDER (PCP) x
- Types of primary care providers x
- How to pick a PCP x
- Freedom to choose your PCP x
- Questions to ask x
- Quick tips about appointments x
- Notice of provider changes or service locations x

GETTING SPECIALIST CARE x
- Prior authorization x
- Definition of "medically necessary services" x
- Out-of -network services x

GETTING A SECOND OPINION x

TRANSPORTATION x

COVERED SERVICES x

NON-COVERED SERVICES x

BEHAVIORAL HEALTH SERVICES x
- Behavioral health crisis x

PHARMACY SERVICES x

Sample

Prescriptions x
Prescription refills x
Mail order prescriptions x
Quick tips about pharmacy services x
Pharmacy Lock-In Program x

DENTAL CARE SERVICES x

VISION CARE SERVICES x

FAMILY PLANNING SERVICES x

PREGNANCY CARE x
Healthy pregnancy tips x
After you have your baby x
Women, Infants and Children (WIC) x

GETTING CARE FOR YOUR NEWBORN x

WELL BABY AND WELL CHILD x
Care for Kids x
Regular checkups x
Checkup schedule x
Immunization (shot) schedule x

CARE MANAGEMENT x

DISEASE MANAGEMENT x

TREATMENT OF MINORS x

NEW MEDICAL TREATMENTS x

TYPES OF CARE x
Emergency care x
Dental emergencies x
Urgent care x
Routine care x

FOLLOW UP CARE
Follow-up after an emergency x
Post stabilization services x

AFTER HOURS CARE x

SELF-REFERRAL x

OUT-OF-SERVICE AREA COVERAGE x

LONG TERM SERVICES AND SUPPORTS x
Health homes x
Integrated health homes x
Community-based care management x
Additional protection, rights and responsibilities x
Role of your care manager x
Self-direction

Sample

Medicare and Medicaid coverage x
Cost share and patient liability x

HEALTH TIPS x
How you can stay healthy x
Guidelines for good health x

If you suspect abuse or neglect x

IF YOU GET A BILL OR STATEMENT x

QUALITY IMPROVEMENT PROGRAMS x

WE WANT TO HEAR FROM YOU x

WHEN YOU HAVE OTHER HEALTH INSURANCE x

GRIEVANCES AND APPEALS x
Grievances x
Appeals x
Utilization management appeals x
How to ask for a quick decision x
State Fair Hearing x

FRAUD, WASTE AND ABUSE x

DISENROLLMENT x
Disenrollment caused by a change in status x
Renewing your insurance x

ADVANCE DIRECTIVES x

COMMON QUESTIONS x

Sample

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Member Handbook

www.aetnabetterhealth.com/iowa

MED-16-009 Iowa High Quality Healthcare Initiative

Helpful information

Aetna Better Health® of Iowa
Member Services
1-855-xxx-xxxx (toll-free)
24 hours a day, 7 days a week

Services for hearing and speech-impaired (TTY)
Call 711

Interpreter service and alternative formats
Call 1-855-xxx-xxxx, TTY 711 if you need help in another language or format. We'll get you an interpreter in your language. You can ask for a verbal or sign language interpreter if you need help talking to your doctor during your visit. You won't need to pay for these services.

If you have a hard time seeing, or you don't read English, you can get information in other formats such as large print or audio. These services are at no cost to you.

Emergency (24 hours)
When you need emergency care, call 911 or go to the closest hospital. The hospital DOES NOT need to be in our network. You don't need preapproval for emergency transportation or emergency care in the hospital.

Mailing address
Street, Suite
Des Moines, IA 50319

Iowa Medicaid
1-855-899-7985, M-F 7 a.m. - 6 p.m.

Vision
1-800-xxx-xxxx (toll-free)

To report fraud or abuse
1-855-xxx-xxxx (toll-free)

Nurse Line
1-855-xxx-xxxx (toll-free)
24 hours a day, 7 days a week

Personal information

My member ID number

My PCP (Primary Care Provider)

My PCP's phone number

www.aetnabetterhealth.com/iowa

Información útil

Aetna Better Health® of Iowa
Servicios al Cliente
1-855-xxx-xxxx (número gratuito)
Disponible las 24 horas del día, los 7 días de la semana

Servicios para personas con dificultades de audición (TTY)
Llame al 711

Servicio de intérpretación y formatos alternativos
Llame 1-855-xxx-xxxx, TTY 711 si necesita ayuda en otro idioma o formato. Te conseguiremos un intérprete en su idioma. Usted puede pedir una verbalo intérprete de lenguaje si necesita ayuda para hablarcon su médico durante su visita. Usted no tendrá que pagar por estos servicios.

Si tiene dificultades para ver, o no lee Inglés, se puede obtener información en otros formatos, tales como letra grande o audio. Estos servicios son sin costo para usted.

Emergencias (las 24 horas)
Cuando usted necesita atención de emergencia, llame al 911 o vaya al hospital más cercano. El hospital no tiene que estar en nuestra red. Usted no necesita aprobación previa para el transporte de emergencia o atención de emergencia en el hospital.

Dirección
Street, Suite 200
Des Moines, IA 50319

Iowa Medicaid
1-855-899-7985, L-V 7 a.m. - 6 p.m.

Visión
1-8xx-xxx-xxxx (número gratuito)

Línea directa para casos de fraude y abuso
1-855-xxx-xxxx (número gratuito)

Línea de enfermería
1-855-xxx-xxxx (número gratuito)
Disponible las 24 horas del día, los 7 días de la semana

Información personal

_____
Mi número de Identificación (ID)

_____
Mi PCP (proveedor de cuidado primario)

_____
Número de teléfono de mi PCP

www.aetnabetterhealth.com/iowa

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AETNA BETTER HEALTH® OF IOWA

Manual para Miembro

www.aetnabetterhealth.com/iowa
828

MED-16-009 Iowa High Quality Healthcare Initiative

AETNA BETTER HEALTH® OF IOWA

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

What do we mean when we use the words "health information"?

We use the words "health information" when we mean information that identifies you. Examples include your:

- Name
- Date of birth
- Health care you received
- Amounts paid for your care

How we use and share your health information

To help take care of you: We may use your health information to help with your health care. We also use it to decide what services your benefits cover. We may tell you about services you can get. This could be checkups or medical tests. We may also remind you of appointments. We may share your health information with other people who give you care. This could be doctors or drug stores. If you are no longer with our plan, with your okay, we will give your health information to your new doctor.

Family and friends: We may share your health information with someone who is helping you, if you give us verbal permission. This permission will allow us to talk with someone that may be helping with your care or helping pay for your care, but only for the day that you give us verbal permission. For example, if you have an accident, we may need to talk with one of these people. If you do not want us to give out your health information call us.

If you are under eighteen and don't want us to give your health information to your parents. Call us. We can help in some cases if allowed by state law.

For payment: We may give your health information to others who pay for your care. Your doctor must give us a claim form that includes your health information. We may also use your health information to look at the care your doctor gives you. We can also check your use of health services.

Health care operations: We may use your health information to help us do our job. For example, we may use your health information for:

- Health promotion
- Case management
- Quality improvement
- Fraud prevention
- Disease prevention
- Legal matters

A case manager may work with your doctor. They may tell you about programs or places that can help you with your health problem. When you call us with questions we need to look at your health information to give you answers.

Sharing with other businesses

We may share your health information with other businesses. We do this for the reasons we explained above. For example, you have transportation covered in your plan. We may share your health information with them to help you get to the doctor's office. We will tell them if you are in a motorized wheelchair so they send a van instead of a car to pick you up.

Other reasons we might share your health information

We also may share your health information for these reasons:

- Public safety – To help with things like child abuse. Threats to public health.
- Research – To researchers. After care is taken to protect your information.
- Business partners –To people that provide services to us. They promise to keep your information safe.
- Industry regulation – To state and federal agencies. They check us to make sure we are doing a good job.
- Law enforcement – To federal, state and local enforcement people.
- Legal actions –To courts for a lawsuit or legal matter.

Reasons that we will need your written okay

Except for what we explained above, we will ask for your okay before using or sharing your health information. For example, we will ask for your okay:

- For marketing reasons that have nothing to do with your health plan.
- Before sharing any psychotherapy notes.
- For the sale of your health information.
- For other reasons as required by law.

You can cancel your okay at any time. To cancel your okay, write to us. We cannot use or share your genetic information when we make the decision to provide you health care insurance.

What are your rights?

You have the right to look at your health information.

- You can ask us for a copy of it.
- You can ask for your medical records for free. Call your doctor's office or the place where you were treated.

You have the right to ask us to change your health information.

- You can ask us to change your health information if you think it is not right.
- If we don't agree with the change you asked for, ask us to file a written statement of disagreement.

You have the right to get a list of people or groups that we have shared your health information with.

You have the right to ask for a private way to be in touch with you.

- If you think the way we keep in touch with you is not private enough, call us.
- We will do our best to be in touch with you in a way that is more private.

You have the right to ask for special care in how we use or share your health information.

- We may use or share your health information in the ways we describe in this notice.
- You can ask us not to use or share your information in these ways. This includes sharing with people involved in your health care.
- We don't have to agree. But, we will think about it carefully.

You have the right to know if your health information was shared without your okay.

- We will tell you if we do this in a letter.

Call us toll free at **1-855-xxx-xxxx,** TTY 711 to:

- Ask us to do any of the things above.
- Ask us for a paper copy of this notice.
- Ask us any questions about the notice.

You also have the right to send us a complaint. If you think your rights were violated write to us at:

Aetna Better Health of Iowa
Attn: Privacy Officer
Street, Suite
Des Moines, IA 50319

You also can file a complaint with regard to your privacy with the U.S. Department of Health and Human Services, Office for Civil Rights. Call us toll free at **1-855-xxx-xxxx,** TTY 711, or go online to "How to File a Complaint" page of the Office for Civil Rights website at **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

If you are unhappy and tell the Office for Civil Rights, you will not lose plan membership or health care services. We will not use your complaint against you.

Protecting your information

We protect your health information with specific procedures, such as:

- Administrative. We have rules that tell us how to use your health information no matter what form it is in – written, oral, or electronic.
- Physical. Your health information is locked up and is kept in safe areas. We protect entry to our computers and buildings. This helps us to block unauthorized entry.
- Technical. Access to your health information is "role-based." This allows only those who need to do their job and give care to you to have access.

We follow all state and federal laws for the protection of your health information.

Will we change this notice?

By law, we must keep your health information private. We must follow what we say in this notice. We also have the right to change this notice. If we change this notice, the changes apply to all of your information we have or will get in the future. We will send you a copy of the new notice, or you can get a copy of the most recent notice on our website at **www.aetnabetterhealth.com/iowa**.

AETNA BETTER HEALTH®

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Iowa High Quality Healthcare Initiative
Member ID# 000000000-00 **Date of Birth** 00/00/0000
Member Name Last Name, First Name **Sex** X

PCP Last Name, First Name
PCP Phone 000-000-0000 **Effective Date** 00/00/0000

RxBIN: xxxxx **RxPCN:** ADV **RxGRP:** RXxxxx
Pharmacist Use Only: 1-855-xxx-xxxx

www.aetnabetterhealth.com/iowa

THIS ID CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT.

Aetna Better Health of Iowa
Street, Suite
Des Moines, Iowa 50319

Members
Member Services & Filing Grievance 24/7 **1-855-**xxx-xxxx, TTY 711
Fraud & Abuse Hotline **1-855-**xxx-xxxx Report Medicaid Fraud **1-**xxx-xxx-xxxx
24 Hour Nurse Line **1-855-**xxx-xxxx Pharmacy **1-855-**xxx-xxxx
Vision Services **1-**xxx-xxx-xxxx

Emergency care: If you are having an emergency, **call 911** or go to the closest hospital. You don't need preapproval for emergency transportation or emergency care in the hospital.

Providers
Provider Services and Prior Authorization **1-855-**xxx-xxxx

Send medical claims to
Aetna Better Health
P.O. Box 6xxxx
Phoenix, AZ 85082-xxxx

Electronic claims
Payer ID 128IO

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AETNA BETTER HEALTH® Of IOWA

Welcome to Aetna Better Health of Iowa

Thank you for choosing us! We look forward to helping you with your health care needs. If you have questions or problems getting services, we are here to help you.

The information below will help you get started. To learn more about your health plan visit our website at **www.aetnabetterhealth.com/iowa.** We look forward to providing your health care benefits!

How to reach us	Call Member Services at **1-xxx-xxx-xxxx, TTY 711,** for questions about your health care coverage.
Member Identification (ID) Card	Included in this packet is your member ID card for each eligible member of your family. Carry it with you and use it whenever you go to the doctor or hospital. Keep it safe and never let anyone else use your ID card.
Your Primary Care Provider (PCP)	Your PCP arranges all of your health care, including sending you to specialists if or when you need one. It is important that you have a PCP and one that you like and will visit. The name and phone number of your assigned PCP are listed on your member ID card. If you want to change your PCP, choose one from the list of providers on our website at **www.aetnabetterhealth.com/iowa** or call us for a provider directory. Call Member Services at **1-xxx-xxx-xxxx, TTY 711**, and we will make the change.
List of providers	Visit our website at **www.aetnabetterhealth.com/iowa** for a list of current providers. You can also call Member Services for a printed directory.
Your first appointment	Take control of your health and schedule an appointment with your PCP today. Your PCP will get to know you and keep you and your family well when you schedule appointments with him or her, even when you are not sick. Regular checkups are especially important for children. Their PCP

Sample

	will make sure your children receives the right shots AND screening for lead exposure. If you are pregnant or plan to be, it is especially important that you see your doctor in order to keep you and baby as healthy as can be! If you are pregnant and do not have a doctor, call Member Services at **1-xxx-xxx-xxxx, TTY 711**, and we will help you find one.
Member handbook	Your member handbook tells you about our plan, your rights and responsibilities, and how you can get care and other services. You can access an electronic copy of the member handbook on our website at **www.aetnabetterhealth.com/iowa**. If you have any questions about the information in the handbook please call Member Services at **1-xxx-xxx-xxxx, TTY 711**.
Member newsletters	The member newsletter covers important topics like benefits, fraud and domestic abuse. It also provides helpful tips for you and your family to live healthier lives. You can find electronic copies of the member newsletters on our website. If you have any questions about the information in the newsletter OR you would like to request a printed copy, please call Member Services at **1-xxx-xxx-xxxx, TTY 711**.
Other languages / formats	The member handbook, member newsletters and other member materials are available in other languages and formats including Braille. Please call Member Services at **1-xxx-xxx-xxxx, TTY 711**, to request other formats or languages.

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Appendix I

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8.7 Health Education Initiative

Iowa Diabetes Flyer
(Pages 837– 838)

Iowa Diabetes Numbers
(Pages 839 – 840)

Iowa Diabetes Eye
(Pages 841 – 842)

Iowa Diabetes Health
(Pages 843 – 844)

Iowa Well-Woman Appt Post Card-F
(Pages 845 – 846)

MLTSS Flyer
(Pages 847 – 848)

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You recently received a mailing that you may be due for some important tests for diabetes.

These important tests are recommended by the American Diabetes Association:

TEST	HOW OFTEN
A1C blood test	Two times a year
Eye exam	Once a year
Kidney test	Once a year

Call today to make an appointment with your primary care provider (PCP)

Ask your PCP about these tests – how often you should have them and if you should have them done now.

SAMPLE

A yearly diabetes eye exam is a covered medical benefit

You don't need a referral to see an eye care provider for your yearly diabetes eye exam. Ask your eye care provider to share your eye exam results with your PCP.

www.aetnabetterhealth.com/iowa

This is general health information and should not replace the advice or care you get from your provider. Always ask your provider about your own health care needs.

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Recientemente recibió un correo sobre la posibilidad de que deba realizarse algunas pruebas importantes para detectar diabetes.

Estas pruebas importantes son recomendadas por la Asociación Americana de Diabetes.

PRUEBA	FRECUENCIA
Prueba de sangre A1C	Dos veces al año
Examen de ojos	Una vez al año
Prueba de función renal	Una vez al año

Llame hoy mismo para solicitar una cita con su proveedor de cuidado primario (PCP)

Consulte a su PCP sobre estas pruebas; averigüe la frecuencia con que debe realizárselas y si debe realizárselas ahora.

SAMPLE

El examen anual de ojos para diabéticos es un beneficio médico cubierto

No necesita una remisión para consultar a un oftalmólogo y realizarse el examen anual de ojos para diabéticos. Pídale a su oftalmólogo que comparta los resultados de su examen de ojos con su PCP.

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Esta es información general de salud y no debe reemplazar el asesoramiento o la atención que usted recibe de su proveedor. Siempre consúltele a este sobre sus necesidades de atención médica.

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Know your numbers: diabetes care checklist

Keep track of your tests and screenings. Review this checklist with your primary care provider (PCP) at each office visit.

Quarterly visits and tests (These tests are done 2-4 times a year)		Year 1 Q1	Year 1 Q2	Year 1 Q3	Year 1 Q4	Year 2 Q1	Year 2 Q2	Year 2 Q3	Year 2 Q4	Year 3 Q1	Year 3 Q2	Year 3 Q3	Year 3 Q4
Hemoglobin A1c (goal is less than 7%[2]) Average blood glucose	Date												
	Result												
Blood pressure (goal is less than 140/90[2])													
Review medications													
Weight (every visit)													

Annual visits and tests (These tests are done once a year)	Year 1 Date	Result	Year 2 Date	Result	Year 3 Date	Result
Dilated retinal exam						
Kidney tests: Urine proteins (microalbumin)						
Serum creatinine (in adults)						
Cholesterol and lipid tests: LDL (goal is less than 100 mg/dl[2])						
HDL (goal for men is above 40 mg/dl[2]) (goal for women is above 50 mg/dl[2])						
Triglycerides (goal is less than 150 mg/dl[2])						

Other annual visits and tests	Year 1 Date	Result	Year 2 Date	Result	Year 3 Date	Result
Dental checkup (twice a year)[1]						
Foot exam						
Immunizations: Flu shot (annual)						
Pneumonia shot						

SAMPLE

Recommended screenings for people with diabetes[2]

Hemoglobin A1c: This is a blood test. The number tells how well your blood sugar has been controlled over the last three months. The goal is less than 7 percent. If you are over the goal, please talk to your PCP.

Dilated retinal exam: This type of eye exam should be done **once a year.** The test is used to find problems that can cause vision loss, if not treated. This exam is different from a routine eye exam for glasses. The eye care provider will use special tests to look at the blood vessels in your eyes. After your exam, please ask your eye care provider to send the results to your PCP.

Kidney testing (microalbumin): This is a urine test. It shows if you need extra care to prevent kidney problems connected to diabetes. If your results are positive, please talk to your PCP.

Serum creatinine: This is a blood test that tells how well your kidneys are working. The American Diabetes Association recommends that this test be done **once a year**. If results are positive, please talk to your PCP.

LDL cholesterol screening: This is a blood test that should be done **once a year**. LDL cholesterol is the "bad" cholesterol. It can build up in your blood vessels and block blood flow. This can lead to heart disease. The goal is less than 100 mg/dl. Talk to your PCP if your results are over the goal.

Dental checkup: People who have diabetes have a higher risk of gum disease. It is important to have dental checkups at least **twice a year** to help avoid problems.

Foot exam: Ask your PCP to check your feet for nerve damage and breaks in the skin **at each visit**. You may not feel sores on your feet. Talk to your PCP if you see a sore on your foot.

[1]American Diabetes Association Oral Health & Oral Hygiene, accessed Jan. 2, 2014. www.diabetes.org/living-with-diabetes/treatment-and-care/oral-health-and-hygiene/oral-health-faqs.html

[2]Goals and recommendations are based on the Standards of Medical Care in Diabetes – Diabetes Care January 2015, vol. 38.

This is general health information and should not replace the advice or care you get from your provider. Always ask your provider about your own health care needs.

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Conozca sus valores: lista de control para el cuidado de la diabetes

Lleve un registro de las pruebas y los exámenes. Revise esta lista con su proveedor de cuidado primerio (PCP) cada vez que visite su consultorio.

Visitas y pruebas trimestrales (Estas pruebas deben realizarse de 2 a 4 veces por año)	Año 1				Año 2				Año 3			
	T1	T2	T3	T4	T1	T2	T3	T4	T1	T2	T3	T4
Hemoglobin A1c (objetivo: menos del 7 %[2]) Glucosa en sangre promedio — Fecha												
Hemoglobin A1c (objetivo: menos del 7 %[2]) Glucosa en sangre promedio — Resultado												
Presión sanguínea (objetivo: menos de 140/90[2])												
Revisión de medicamentos												
Peso (todas las visitas)												

Visitas y pruebas anuales (Estas pruebas deben realizarse una vez por año)	Año 1 Fecha	Resultado	Año 2 Fecha	Resultado	Año 3 Fecha	Resultado
Examen de retina con pupila dilatada						
Pruebas de función renal — Proteínas en la orina (microalbúmina)						
Pruebas de función renal — Creatinina en suero (para adultos)						
Prueba de colesterol y lípidos — LDL (objectivo: menos de 100 mg/dl[2])						
Prueba de colesterol y lípidos — HDL (objetivo para hombres es más de 4[illegible] mg/dl[2]) (objetivo para mujeres es más de 50 mg/[illegible])						
Prueba de colesterol y lípidos — Triglicéridos (objetivo: menos de 150 mg/dl[2])						

Otras visitas y pruebas anuales	Año 1 Fecha	Resultado	Año 2 Fecha	Resultado	Año 3 Fecha	Resultado
Chequeo dental (dos por año)[1]						
Examen de pies						
Vacunas — Vacuna contra la gripe (anual)						
Vacunas — Vacuna contra la neumonía						

SAMPLE

Exámenes recomendados para personas con diabetes[2]

Hemoglobin A1c: Esta es una prueba de sangre. El valor indica qué tan bien se controló el nivel de azúcar en sangre durante los últimos tres meses. El objetivo es tener un nivel inferior a 7 %. Si su nivel es superior, hable con su PCP.

Examen de retina con pupila dilatada: Este tipo de examen ocular debe realizarse **una vez por año**. Este examen sirve para detectar problemas que, si no se tratan, pueden causar la pérdida de la vista. El examen es no es igual al examen ocular de rutina para recetar lentes. El oftalmólogo utiliza este examen especial para observar los vasos sanguíneos de los ojos. Luego de realizarse el examen, pídale a su oftalmólogo que le envíe los resultados a su PCP.

Prueba de función renal (microalbúmina): Esta es una prueba de orina. Le indicará si necesita atención adicional para prevenir problemas renales relacionados con la diabetes. Si su resultado es positivo, hable con su PCP.

Creatinina en suero: Esta es una prueba de sangre. Le indica cómo funcionan sus riñones. La Asociación Americana de la Diabetes recomienda realizarse esta prueba **una vez por año**. Si su resultado es positivo, hable con su PCP.

Prueba de colesterol LDL: Esta es una prueba de sangre que debe realizarse **una vez por año**. El colesterol LDL es el colesterol "malo". Puede acumularse en los vasos sanguíneos y obstruir el flujo de la sangre, lo que puede provocar enfermedades cardíacas. El objetivo es tener menos de 100 mg/dl. Hable con su PCP si su resultado es superior.

Chequeo dental: Las personas que padecen diabetes tienen un mayor riesgo de contraer enfermedades de las encías. Es importante que se realice chequeos dentales por lo menos **dos veces por año** para evitar estos problemas.

Examen de pies: Pídale a su PCP que le revise los pies para detectar daño nervioso o cortes en la piel **en todas las visitas**. Posiblemente no sienta las llagas en los pies. Hable con su PCP si tiene llagas en los pies.

[1]American Diabetes Association Oral Health & Oral Hygiene. Disponible en www.diabetes.org/living-with-diabetes/treatment-and-care/oral-health-and-hygiene/oral-health-faqs.html. Consultado el 2 de enero de 2014.

[2]Los objetivos y las recomendaciones se basan en los estándares de atención médica para pacientes con diabetes de la Standards of Medical Care in Diabetes – Diabetes Care January 2015, vol. 38.

Esta es información general de salud y no debe reemplazar el asesoramiento o la atención que usted recibe de su proveedor. Siempre consúltele a este sobre sus necesidades de atención médica.

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Your PCP wants to know about your eye test

This form will help your eye care provider contact your primary care provider (PCP) with your test results.

Help your eye care provider communicate with your PCP

- Write your PCP's name, address and phone number in the form to the right.
- Write your name, address, phone number and date of birth in the form. Please add the ID number from your ID card.
- Give this form to your eye care provider.
- Remind your eye care provider that you have diabetes.
- Ask your eye care provider to fill out the rest of the form and send it to your PCP.

This is general health information and should not replace the advice or care you get from your provider. Always ask your provider about your own health care needs.

Section I (please print)

PCP information	Patient information
Name	Name
Address	Address
Telephone	Telephone
Fax	Date of birth
	Plan ID number

Eye care provider, please complete section II and send to the patient's PCP, named above.

SAMPLE

Section II (please print)

Eye care provider information	
Name of eye care practice/facility	
Name of eye care provider	
Address	
Telephone	Fax

Eye exam information	
Date of eye exam	
Patient received dilated retinal exam with the following results: ___ Diabetic retinopathy was not detected ___ Diabetic retinopathy was detected ___ This patient requires additional testing and/or treatment	
Comments	
Patient should return for reevaluation in _____ months	
Eye care provider signature	

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Su PCP desea tener información sobre su examen de ojos

Este formulario sirve para que su oftalmólogo le comunique a su proveedor de cuidado primario (PCP) los resultados de su examen.

Colabore con su oftalmólogo para que pueda comunicarse con su PCP

- Escriba el nombre, la dirección y el número de teléfono de su PCP en el cuadro.
- Escriba su nombre, dirección, número de teléfono y fecha de nacimiento en el cuadro. Agregue el número de su tarjeta de identificación.
- Entregue este formulario a su oftalmólogo.
- Recuérdele que usted tiene diabetes.
- Pídale que complete el resto del formulario y se lo envíe a su PCP.

Esta es información general de salud y no debe reemplazar el asesoramiento o la atención que usted recibe de su proveedor. Siempre consúltele a este sobre sus necesidades de atención médica.

Sección I (completar en letra de imprenta)

Información del PCP	Información del paciente
Nombre	Nombre
Dirección	Dirección
Teléfono	Teléfono
Fax	Fecha de nacimiento
	N.º de ID del plan

Oftalmólogo: complete la sección II y envíe el formulario al PCP del paciente mencionado arriba.

SAMPLE

Sección II (completar en letra de imprenta)

Información del oftalmólogo	
Nombre del centro o consultorio de oftalmología	
Nombre del oftalmólogo	
Dirección	
Teléfono	Fax

Información del examen de ojos
Fecha del examen de ojos
Se realizó al paciente un examen de retina con pupila dilatada y se obtuvieron los siguientes resultados: ___ No se detectó retinopatía diabética ___ Se detectó retinopatía diabética ___ El paciente necesita pruebas o tratamientos adicionales
Comentarios
El paciente debe volver a evaluarse dentro de _____ meses
Firma del oftalmólogo

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Being active and eating right is important to staying healthy

Being active and eating well helps you feel good. It also can help control your blood pressure, blood sugar and cholesterol.

Stay active

Physical activity is anything that gets your body moving. It doesn't have to be hard and you don't have to do it alone. The key to staying active is doing things that you enjoy and changing your exercise routines to keep from getting bored. Ask your primary care provider (PCP) what exercises are right for you.

Keep your plan simple. Start slowly and work up to the following:

- **For your heart:** 30 minutes of moderate activity, at least five days a week. Do exercises that will temporarily increase your breathing and heart rate. Try walking, biking, swimming, dancing.
- **For your muscles:** 30 minutes of exercises at least two days a week. Try lifting weights, exercise bands, even yard work.

If you are feeling dizzy or feel weakness, stop immediately and call your PCP.

Eat right

Making a well-balanced diet part of your everyday life isn't easy. Below is information about the basic food groups:

- Grains – whole grains are the best choice.
- Fruits – eat a variety of fruits. Choose whole fruit rather than juice.
- Vegetables – eat more dark green vegetables.
- Choose fat-free or low-fat milk and milk products.
- Lean meats, poultry, and fish – bake, broil or grill your meat. Avoid fried foods.
- Nuts, seeds, beans and peas are good sources of protein.
- Make fruits and vegetables half of your plate.

Eat less salt and sugar. Follow these tips:

- Avoid processed foods like lunchmeat or canned soup.
- Drink water instead of sugary drinks.

Eating right is not just about what you eat. It's also about how much you eat. Stay clear of oversized portions, especially when eating out. Take part of your meal home to eat later.

Know your numbers

Staying active and eating right helps to keep your blood sugar, blood pressure and cholesterol under control.

Ask your PCP:

- What your numbers are
- When you should have them checked
- What your goal should be for each number

Knowing your numbers helps you and your PCP know your risks. It will also help you track the progress you're making toward a healthier you.

Partner with your PCP

Your PCP can help you keep on track to staying healthy.

- Talk to your PCP about the exercise and the diet plan you are following.
- Make a list of questions and concerns before you go to see your PCP. Start with these three questions :
  - What is my problem?
  - What do I need to do?
  - Why is this important to me?

Keep asking questions until you understand the answers.

Go to our website to check out more information on health: **www.aetnabetterhealth.com/iowa**. You can learn about health topics and care studied by doctors. Stay healthy by using our tools to help control your health. Community resources and discount programs are also just a few clicks away.

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www.aetnabetterhealth.com/iowa

This is general health information and should not replace the advice or care you get from your provider. Always ask your provider about your own health care needs.

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Estar activo y alimentarse bien es importante para mantenerse saludable

Estar activo y alimentarse bien lo ayuda a sentirse bien. Además, lo puede ayudar a controlar la presión sanguínea, el nivel de azúcar en sangre y el colesterol.

Manténgase activo

La actividad física es cualquier actividad que ponga a su cuerpo en movimiento. No hace falta que sea muy intensa ni que la realice solo. La clave para mantenerse activo es hacer actividades que disfrute y cambiar su rutina de ejercicios para no aburrirse. Pregúntele a su proveedor de cuidado primario (PCP) qué tipo de ejercicio es adecuado para usted.

Mantenga un plan simple. Comience de a poco hasta lograr lo siguiente:

- **Para su corazón:** 30 minutos de actividad moderada, por lo menos cinco días a la semana. Realice ejercicios que aumenten temporalmente su frecuencia cardíaca y ritmo respiratorio. Trate de caminar, andar en bicicleta, nadar o bailar.
- **Para sus músculos:** 30 minutos de ejercicio por lo menos dos días a la semana. Intente levantar pesas, ejercitar con bandas, incluso realizar tareas de jardinería.

Si se siente mareado o débil, deténgase inmediatamente y llame a su PCP.

Aliméntese bien

No es fácil mantener una dieta balanceada en su vida cotidiana. A continuación se brinda información sobre los grupos de alimentos básicos:

- Granos: Los granos integrales son la mejor opción.
- Frutas: Coma frutas variadas. Elija frutas enteras en vez de jugos.
- Vegetales: Consuma más cantidad de vegetales de color verde oscuro.
- Elija leche y productos lácteos descremados o bajos en grasas.
- Carnes bajas en grasas, aves de corral y pescado asados al horno o a la parrilla. Evite los alimentos fritos.
- Los frutos secos, las semillas, las legumbres y los chícaros son buenas fuentes de proteínas.
- Cubra la mitad de su plato con frutas y vegetales.

Consuma menos sal y grasas. Siga los siguientes consejos:

- Evite los alimentos procesados, como hamburgesas y sopas enlatadas.
- Beba agua en vez de bebidas con azúcar.

Alimentarse bien no se trata únicamente del tipo de alimentos que consume, sino también de la cantidad que consume. Evite las porciones demasiado grandes, especialmente cuando salga a comer afuera. Lleve parte de la comida a su casa para comerla más tarde.

Conozca sus valores

Estar activo y alimentarse bien lo ayuda a controlar el nivel de azúcar en sangre, la presión sanguínea y el colesterol.

Consulte a su PCP sobre lo siguiente:

- cuáles son sus valores
- cuándo debe controlarlos
- qué valores debe establecerse como objetivo

Conocer sus valores lo ayuda a usted y a su PCP a saber cuáles son sus riesgos. También lo ayudará a evaluar su progreso hacia una vida más saludable.

Trabaje junto a su PCP

Su PCP puede ayudarlo a llevar una vida saludable.

- Hable con su PCP sobre el plan de ejercicios y alimentación que lleva.
- Haga una lista de preguntas e inquietudes antes de visitar a su PCP. Comience con las siguientes tres preguntas:
  - ¿Cuál es mi problema?
  - ¿Qué debo hacer?
  - ¿Por qué es importante para mí?

Siga preguntando hasta que comprenda las respuestas.

Visite nuestro sitio web para ver más información sobre la salud: **www.aetnabetterhealth.com/iowa**. Podrá aprender sobre temas relacionados con la salud y la atención estudiados por médicos. Manténgase saludable utilizando nuestras herramientas para ayudar a controlar su salud. También podrá acceder a recursos de la comunidad y programas de descuentos haciendo tan solo unos clics.

SAMPLE

www.aetnabetterhealth.com/iowa

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My well-woman appointment

My appointment is with: _____

Questions to ask: _____

_____

_____

Where: _____

When: _____

Happy Birthday!
¡Feliz cumpleaños!

This is general health information and should not replace the advice or care you get from your provider. Always ask your provider about your own health care needs.

Esta es información general de salud y no debe reemplazar la atención que usted recibe de su proveedor de atención de salud. Tampoco tiene como objetivo reemplazar el asesoramiento que recibe de su proveedor de atención de salud. Siempre solicite a este información sobre sus necesidades de atención médica.

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Street
City State ZIP

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Happy Birthday!
¡Feliz cumpleaños!

Give yourself the best gift ever: Peace of mind.

Call for your yearly well-woman exam today!

Your visit may include a:

- Review of your health concerns
- Physical examination tailored to your needs
- Pap test (if needed)
- Human papillomavirus (HPV*) test (if needed)
- Screening test for infections or diseases (if needed)
- Discussion about your family planning needs

Make a list of questions to take with you to your visit. Find out what's right for you.

Getting a cervical cancer screening (Pap test) is an important part of a woman's health care. This test can find problems before you have any signs. If there is a problem, there is a better chance for a cure.

Ask if you need a Pap test this year. If you are 30 years of age, or older, ask if you need an HPV test. If you need one, there will be no cost to you. Check with your primary care provider (PCP) or OB/GYN.

It could save your life. It can give you peace of mind.

*HPV is a virus that may lead to cervical cancer.

If you need help finding a PCP or OB/GYN, we can help. Please call us toll-free at **1-XXX-2XX-XXXX, TTY 711**

www.aetnabetterhealth.com/iowaa

Hágase el mejor regalo que jamás se haya hecho: tranquilidad.

¡Llame hoy mismo para realizarse el examen de mujeres sanas anual!

Es posible que durante su visita:

- Se analicen sus preocupaciones de salud
- Se ajuste el examen físico a sus necesidades
- Se le realice una prueba de Papanicolaou (si fuera necesario)
- Se le realice un examen para detectar el virus del papiloma humano* (si fuera necesario)
- Se le realice un examen para detectar infecciones o enfermedades (si fuera necesario)
- Se converse acerca de sus necesidades de planificación familiar

Escriba una lista de preguntas para llevar a su visita. Averigüe qué es lo mejor para usted.

Realizarse el examen de cáncer de cuello uterino (prueba de Papanicolaou) es parte importante de la atención de salud de una mujer. Este examen puede detectar problemas antes de que usted tenga algún síntoma. Si se detecta algún problema, será mayor la posibilidad de hallar una cura.

Pregunte si necesita realizarse una prueba de Papanicolaou este año. Si tiene 30 años de edad o más, pregunte si necesita hacerse el examen para detectar el virus del papiloma humano.

Si necesita realizarse alguno de estos estudios, usted no pagará ningún costo. Consulte con su proveedor de cuidado primario o con su obstetra/ginecólogo.

Podría salvar la vida. Y siempre le tranquilidad.

*El virus del papiloma humano puede causar cáncer de cuello uterino.

Si necesita ayuda para encontrar un proveedor de cuidado primario o un obstetra/ginecólogo, cuenta con nosotros. Llámenos al número gratuito **1-8XX-XXX-XXXX, TTY 711**

www.aetnabetterhealth.com/iowa

SAMPLE

Mi bien-mujer nombramiento

Mi cita es con: _____

Preguntas que debe hacer: _____

_____

_____

Donde: _____

Cuando: _____

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You are the center of what we do

At Aetna Better Health of Iowa, we want you to get the long term services and support you need, when you need them.

We make it easy for you

- Choose your own doctors from our many providers
- Get help in any language you need
- User-friendly website

Care managers

- Managed long term services and supports care manager meets with you where you live to coordinate your care and benefits
- Together, we create a care plan just for you

Trained and dedicated staff

- Work with you, your family, your caregivers and doctors to get the care and services you need
- Help you understand your health conditions
- Let you know about our special care programs for lung disease, diabetes and heart disease

Our benefits work for you

Whether you live in a nursing home, community or home setting, our managed long term service and support benefits work to keep you independent and active.

As a part of Aetna, we are a proven leader in health care. Let us help you meet your health care needs.

Learn more by calling 1-8XX-XXX-XXXX, TTY 711

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Appendix J

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8-8 (Q2) Sample Explanation of Benefits

Provider of Service:	PROVIDER, DOCTOR STREET ADDRESS CITY, STATE ZIP	Claim Number:	XXXXXXXXX
		Patient Name:	MEMBER NAME
		Claim Status:	DENIED

									Member Responsibility		
Line #	Dates of Service (From – Thru)	Description	Serv Code	Mod	Rev Code	Billed Amount	Allowable Amount	COB Amount	Non-Covered Charges	Co-Pay	Plan Pays
1	03/28/05	OCCUPATIONAL THERAPY EVALUATION	97003			95.00	78.65	0.00	95.00	0.00	0.00
					Claims Totals:	95.00	78.65	0.00	95.00	0.00	0.00

Code/Description
96 – Non-covered charge(s)

The claims for services you received were denied. The services are not covered under the State Medicaid Plan. You may be billed for these services.

You may be responsible for the amount not paid. Please call Member Services at 1-800-822-2447 or TTY 1-800-628-3323:

- If you did not receive these services
- If you have any other questions regarding this explanation of benefits.

If you suspect fraud or abuse involving the services described in this Explanation of Benefits or would like to report other healthcare fraud related issues, please call the toll-free Compliance Hotline at 1-800-333-0119 or submit a form via www.aetnabetterhealth.com/iowa.

Sincerely,
Member Services

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Appendix K

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9.1.2 (Q1)Health Risk Assessment Tool

Care Plan Interview (Non-LTSS Member)

Instructions: *CM to review care team participant overlay and HIPAA. Obtain consent from the member prior to completing assessment with anyone other than the member.*

CPI Module conducted with:
• Member • Parent/Guardian • Foster Parent • Spouse • Son/Daughter • Significant Other • Other: _____

- Clinical History and Utilization
- Medication
- Functional Level
- Living Environment/Support
- Self Care
- Providers/Other Services

1. Clinical History and Utilization Module

Q#	Question/Selections
C1	CONFIRM list of conditions that system shows. **"I can see from questions you (or your child) have previously answered, it looks like you have: _____", Are there any other conditions you have been told you have?** • **Currently Pregnant*** • ADHD* • An autoimmune disorder like RA, Lupus, Myasthenia Gravis (weak muscles),ITP (bleeding disorder) • Autism * • Blood disorder – Hemophilia • Blood disorder – Other: _____ • Blood disorder - Sickle cell disease or sickle cell trait [+ Pregnant = HIGH RISK]* • Blood Pressure problems like hypertension [+ pregnant = HIGH Risk • Bone or joint problems like arthritis, amputation, chronic low back pain • Bowel or Stomach problems like ulcers, chronic diarrhea • Breathing problem – Asthma* • Breathing problem - Chronic bronchitis [+ pregnant = HIGH Risk] • Breathing problem - COPD [+ pregnant = HIGH Risk] * • Breathing problem - Emphysema [+ pregnant = HIGH Risk] • Breathing problems – Other: _____ • Cancer * • Cerebral Palsy • Chronic Pain • Congestive Heart Failure [+ pregnant = HIGH Risk] * • Cystic Fibrosis • Developmental disability *

- Diabetes [+ pregnant = HIGH Risk] *
- Endocrine issues other: (thyroid, hormone problems)
- Hearing Problems like deafness, hearing aids
- Heart problems like Coronary Artery disease or Heart attack [+ pregnant = HIGH Risk
- Infection problems like HIV/AIDS,TB [+ pregnant = HIGH Risk]
- Kidney problems like chronic infection or dialysis [+ pregnant = HIGH Risk] *
- Lead *
- Liver problems like chronic hepatitis or cirrhosis [+ pregnant = HIGH Risk]
- Mental health problems like depression or anxiety *
- Nerve/brain: Stroke, Multiple Sclerosis, Spinal Cord, paralysis, Epilepsy/Seizures, Traumatic brain injury
- Sleep apnea
- Spina Bifida
- Substance abuse (alcohol or drug abuse) [+ pregnant = HIGH Risk] *
- Transplant (specify type: Liver, Pancreas, heart, lung, intestinal) *
- Vision Problems like blindness, cataracts
- Other (Please list): _____
- No Condition

CM INSTRUCTIONS: If category is broad, ask member to tell you more, document specifics

**If the following conditions are indicated complete the related activity:*

- If PREGNANT: Complete Perinatal assessment
- If PREGNANT and TOBACCO user was selected on Outreach questionnaire (see the INFORMED BY COLUMN FOR THE QUESTION and member is 18 years or over: Complete UNCOPE Screener
- If PREGNANT and TOBACCO user was selected on Outreach questionnaire (see the INFORMED BY COLUMN FOR THE QUESTION and member is 18 years or over: Complete UNCOPE Screener
- If PREGNANT and TOBACCO user was selected on Outreach questionnaire (see the INFORMED BY COLUMN FOR THE QUESTION and member is 18 years or over: Complete UNCOPE Screener
- If PREGNANT and TOBACCO user was selected on Outreach questionnaire (see the INFORMED BY COLUMN FOR THE QUESTION and member is < 18 years: Complete CRAFFT Screener
- If ADHD and the member is <18 complete PSC17 OR make referral for evaluation
- If AUTISM and the member **< 18** complete PSC17 OR make referral for evaluation
- If BLOOD Disorder: SICKLE CELL disease or Sickle cell trait: Consider completion of Sickle cell assessment (optional, unless State required)
- If ASTHMA complete Asthma assessment
- If COPD and member **18 or over** complete the COPD assessment and K6. If member **<18** complete the COPD assessment and PSC17
- If Cancer consider completion of Cancer assessment (optional, unless State required)
- If CHF and member **18 or over** complete the CHF assessment and K6. If member **<18** complete the CHF assessment and PSC17
- If Developmental Disability and member **< 18** complete PSC17 OR make referral for evaluation
- If Diabetes complete the Diabetes assessment
- If Kidney problems consider completion of End-stage Renal Failure Assessment (optional unless State required)
- If Lead complete Lead questionnaire (only if State required)
- If Mental Health problems and member is **18>** complete K6 and UNCOPE or make referral for BH assessment, if member is **>4 but <18** complete PSC17 and CRAFFT or make referral for BH assessment
- If Substance Abuse and member is **18 or over** complete K6 and UNCOPE or make referral for BH assessment, if member is **>4 but <18** complete PSC17 and CRAFFT or make referral for BH assessment

	• If Transplant complete Transplant (pre and post) Assessment (optional, unless State required) - insert the specific type of transplant into the task text **Follow Up Question** (not mandatory): • Does that fit your understanding of your health conditions? • Do you need something NOW to help with any of these conditions? • Are you comfortable managing your symptoms? • Do you know when to call your doctor about your symptoms?
C2	**Which of your conditions worries you most and why?**
C3	**In the last 6 months, were you sick enough to stay the night in the hospital?** • Yes, Medical • Yes, Mental Health • Yes, Detoxification • No *CM INSTRUCTIONS: If data from HRQ, CORE or PPM is available – we have some answers to the ED/IP question. Therefore, just be open and ask about what we know. Being open/honest with the member about what we do know works to establish a trusting relationship.* **Follow up questions** (not mandatory): • Tell me about the instructions you were given when you were discharged? • Have you been able to follow the instructions? • Did you receive the medication, supplies/services that were recommended for you when discharged?
C4	**Have you been to the emergency room in the past six months?** • Yes, Medical • Yes, Mental Health • Yes, Detoxification • No
C5	**(If ER = yes) Why did you go to the emergency room?** • I believed it was true emergency • I "just went" to the ER • My PCP was not available, so I went to the ER • My PCP or other provider instructed me to go to the ER • I did not contact my PCP prior to going to the ER • Urgent Care instructed me to go • I ran out of medication • Other **Follow up questions** (not mandatory): • Was this related to one or more of your conditions? • Is there an urgent care close to your home?
C6	**"Some people use special things to help them in their day-to-day life. These include things like a cane, wheelchair, or a special bed." What special equipment do you use or need to take care of yourself?** • AB monitor • Bedside commode • Blood glucose monitor • Blood pressure monitor • Breathing machine (CPAP, BIPAP, tracheotomy, ventilator) • CAD pump • Catheter supplies

	• Crutch • Communication devices • Cough assistance vest • Diabetic pump • Feeding pump and tube feeding supplies • Glucometer • Grab bars (shower) • Incontinence supplies • Insulin pump • IV pump • Mechanical Left (Hoyer Lift) • Nebulizer/humidifier • Ostomy supplies • Oxygen • Pain pump • Peak Flow meter • PICC Line • Power Scooter • Prosthesis/braces • Raised toilet seat • Scale • Shower chair/bench • Specialty bed/mattress • Suction machine • SVN machine • Tracheostomy supplies • Ventilator • Walker/cane • Wheelchair • Wound supplies • Wound VAC • Other • None **Follow up questions** (not mandatory): (Prompt as appropriate based on condition list) • Do you know how to use the equipment? • How helpful is the machine to you? • Do you need any assistance getting your equipment? • Are your supplies in working order? • Do you know how to use them?
C7	**QUESTION FOR CHILD ONLY - For kids equal or less than 2 –** **Has your child had regular check-ups and shots?** • YES • NO *EDUCATE: If appropriate, discuss standards of care for check-ups and immunizations. Visiting a child's PCP when the child is well is a good time to get questions answered about proper development, for child to become comfortable with provider, and for the provider to see what is normal for child when child is not sick.* **Follow Up Question (not mandatory):** Is child scheduled to receive any of these services? • YES • NO •

C8	**FOR KIDS OVER 2 UP TO 18 –** **Within the past year, has your child had a:** • Well Care check-up • Dental visit • None of these *EDUCATE: If appropriate, discuss standards of care for check-ups and immunizations. Visiting a child's PCP when the child is well is a good time to get questions answered about proper development, for child to become comfortable with provider, and for the provider to see what is normal for child when child is not sick.* **Follow Up Question** (not mandatory): Is your child scheduled to receive any of these services? • YES • NO

2. Medication Module

Q#	Question/Selections
M1	IF NO KNOWN DATA ABOUT MEDICATIONS AND: **"I would really like to go over all the medications you are taking. This will help me understand your situation better. Do you have time to get your pill bottles?"** OR IF MEMBER PHARMACY IS AVAILABLE, SAY: **"I can see from our notes, that you have taken medicine for _____ conditions. "** **EDUCATE: CM Instructions:**

If….	Then….
Member does not have time or does not have pill bottle(s)	Ask "When would be a good time to do this? And set a task for yourself to complete the review with the member
Medication is NOT on the Pharmacy overlay	Enter data into medication event
Member is pregnant	Advise member to stop taking OTC or herbal supplements until member can talk to their doctor about the OTC or herbal supplements

CM INSTRUCTIONS: CONFIRM medications in system / Add or remove others as needed into Medication event.

Follow Up Questions (not mandatory):
- Are the meds helping you?
- Do you feel like you have to take more medications to get relief from your symptoms?
- When people are taking several pills, it sometimes become confusing. How do you do it?
- Are you taking the medicine as prescribed?

M2	**"A lot of people take other things like vitamins, aspirin, or herbs." Do you take other medicines that you buy at the store?** • YES • NO *CM INSTRUCTIONS: Document specific medications in the medication event.*

M3	**Have you stopped taking any pills or medicine and NOT told your doctor? If so, please tell me the reason:** • No • Yes, can't afford • Yes, no transportation • Yes, makes me feel bad • Yes, forget to take * • Yes, don't understand what they are for or how to take them * • Yes, unable to get appointment with provider for re-fills • Yes, still have symptoms even when I take the medication • Yes, there are too many to take • Yes, when I feel good, I stop taking the medication • Yes *EDUCATE: Have member explain what is needed to be compliant with medication, address any identified barriers to medication adherence, address literacy issues or health beliefs that may be affecting treatment* **If the following responses are indicated complete the related activity:* • If "Yes, forget to take": *Create strategy with member for medication reminders* • If "Yes, don't understand what they are for or how to take them": *Ensure member knows how to take and understands the importance of the medication and refer to prescriber for questions about meds* **Follow up question** (not mandatory): Since you first answered this question, have you told your doctor? (Free text)

3. Functional Level Module

Q#	Question/Selections
	Always show if member is 18 or over: Complete initial SF8 Always show if member is <18: Complete initial SF10
F1	**"Now I'm to ask you about some every-day activities. Is this okay?" Are you currently…?** • Working outside of your home • Out of work for more than 1 year • Out of work for less than 1 year • A homemaker • A student • Retired • Unable to work • Not employed **Follow up questions** (not mandatory): a) What do you do? b) How many days a week do you work? c) Do you enjoy what you do? d) If out of work say: That must be stressful for you, how are you handling that?
F2	**Do you (or your child) have trouble with any of the following:** • Eating • Dressing • Walking • Transferring (e.g. getting out of bed or chair) • Bathing

	• Toileting • Talking • Reading or writing • Solving problems • Being able to do more than one thing at a time • Concentrating • Remembering things (short and long-term memory) • Doing laundry • Preparing meals • Housekeeping • Shopping • Taking/getting medications • Transportation • Finances • Using the telephone • Confusion • Coherency • Orientation to person Orientation to time/day Orientation to place Lethargy • Unresponsive • None – member is alert • None of the above
F3	**"Now I want to understand a little more about your moods", is this ok? Some people have thoughts or feelings that get in the way of doing what they want to do. How often does this happen to you?** • Never • Hardly ever • Quite often* • All the time* **If the following responses are indicated complete the related activity:* • "Quite often": *if member is **18 or over** complete K6 and UNCOPE or make referral for BH assess,* *if member is member is **> 4 and < 18** complete PSC17 and CRAFFT or make referral for BH assess* • "All the time": *if member is **18 or over** complete K6 and UNCOPE or make referral for BH assess,* *if member is member is **> 4 and < 18** complete PSC17 and CRAFFT or make referral for BH assess* **Follow up question** (not mandatory): • Have you had recent problems with _____ (in last 30 days)? • Have you had recent problems with any of the following (in last 30 days): o Being anxious o Hearing voices or seeing things others cannot see o Delusions o Agitation, fighting or arguing with others o Being combative with others o Thoughts of hurting yourself o Thoughts of hurting others o Feeling down, depresses, lonely or hopeless o Little interest or pleasure in doing things

F4	**"Many things can help your condition(s). And many things can make your condition(s) worse. I would like to ask a question about your drug and alcohol use." How many times in the last month did you have more than 4-5 drinks (alcohol) at once?** • 1 or more times • None **If the following responses are indicated complete the related activity:* • "1 or more times"*: if member is **18 or>** complete K6 and UNCOPE or make referral for BH assessment;* *if member is **>4 and <18** complete PSC17 and CRAFFT or make referral for BH assessment* **Follow up question** (not mandatory): Since you found out you were pregnant have you consumed alcohol?
F5	**How many times in the last month did you use drugs not prescribed for you by your doctor (including over-the-counter, prescription, herbal and street drugs)?** • 0 • 1 • 2 • 3 • More than 3 **Follow up question** (not mandatory): a) Can you tell me what you've been taking/using? b) How much have you been taking/using? c) How often are you taking/using this/these? d) When did you start taking/using these?
F6	**In the last month that school has been (or was) open, did your child go to school every day?** • Yes, parent aware of no days missed • 1-3 days missed • More than 3 days missed • N/A – child not school age
F7	**What is the main reason your child did not go to school on those days?** • Sick/hurt • Transportation issues • Appointments • Had to take care of family responsibilities • Skipped school * • Behavior issues * • Other * **If the following responses are indicated complete the related activity:* • "Skipped school": *complete PSC17 or make referral for BH assessment* • "Behavior issues": *complete PSC17 or make referral for BH assessment* • "Other": *complete PSC17 or make referral for BH assessment*

4. Living Environment/Support Module

Q#	Question/Selections
L1	**How many different addresses have you had in the last 12 months?** • Only 1 address in last year • 2-3 addresses • More than 3

	• I am homeless right now **<u>Follow up question</u>** <u>(not mandatory):</u> • You've moved a lot, what's happened to cause that? • You've been in the same place for a while, do you anticipate moving soon?
L2	**How many people live with you?** • Enter number
L3	**What is your current living environment?** • Lives alone • Spouse/Significant other • Lives with friends • Lives with family • Foster Care home • Assisted Living home • Assisted Living center • Alzheimer's Assisted Living • SNF • SNF-Wandering Dementia • Behavioral Health placement • TBI Placement • Homeless Single parent home • Two parent home • Single foster parent/guardian home • Other *(please note in narrative)* **<u>Follow up question</u>** <u>(not mandatory):</u> • How many children under 5 live in the home? • Are the people you live with relatives? Friends? • Would you say the relationships with the people you live with are great, good, fair, poor? • Does anyone you live with threaten or physically hurt you? • Are the people you live with using any substances?
L3.1	**Because violence is so common in many people's lives, I've begun to ask all my members about it." Are you currently or have you ever been in a relationship where you were physically hurt, threatened, or made to feel afraid?** • YES • NO
L4	*CM INSTRUCTION: If YES above, Ask: Are you in immediate danger? Is it OK to continue talking? (Do you have the privacy to complete our interview today?)* Do you feel safe at home? • YES • NO *CM INSTRUCTION: If no, assess safety situation and provide referrals to services that can assist member, e.g. domestic violence shelter, safe housing, legal services. The response here is dependent on what the safety issue is (e.g. domestic violence versus random gunfire in the neighborhood)* **<u>Follow up question</u>** <u>(not mandatory):</u> • Why do you not feel safe?

	• Within the past year have you been hit, slapped, kicked or otherwise physically hurt by someone?
	• Are you in a relationship with a person who threatens or physically hurts you?
	• Has anyone forced you to have sexual activities that made you feel uncomfortable?
	  o Do you currently live with this person?
	  o How often does this happen?
	• Have your children been hurt or threatened too?
	• Are any authorities like CPS or Police involved?

L5	**"I would like to ask you about other people who may be a part of your life." When you need help in day to day life, is there someone you can count on?** • No one • Spouse • Parent • Sibling • Friend/neighbor • Caregiver • Son/daughter • Other **Follow up question** (not mandatory): • Tell me about that relationship. How do/does this person(s) help you? • Do you have someone we can speak with who you are comfortable with assisting in coordinating your care? • Would you like for us to be able to talk to any of these regarding your condition? If so, who?
L6	**Does anyone help you make and get to your appointments?** • No • Yes, a family member *(document)* • Yes, a friend *(document)* • Yes, other *(document)* **Follow up question** (not mandatory): • In order for me to talk to another person about your healthcare, I need to have a release form. Would you be willing to complete a form so that I can do that? *(BACK TO TOP)*

5. Self Care Module

S1	**"There are many things that people do to help manage their health and take care of themselves. Knowing what works for you is important to think about as we make plans for working together." Can you tell me some things you do to take care of yourself?** • Sleep 7-8 hours • Exercise • Eat well • Have fun • Hobbies • Meditation/relaxation • Spiritual/religion • Medication adherence • Talk to friends/family • I don't feel like I take care of myself at all • Other **Follow up question** (not mandatory):

	• Which of these seem to help you feel the best? • When things are going well, what things do you do? • When was the last time you did these things? • How often do you participate in these activities? • Do they help?
S2	**Has a doctor or provider ever asked you to follow a certain type of diet?** • No • Yes – Renal diet • Yes – ADA- Diabetic diet • Yes – Kosher diet • Yes – Low salt/sodium diet • Yes – Weight management • Yes – Other **Follow up question** (not mandatory): • On a normal day, tell me what you eat for breakfast, lunch and dinner? • How much water do you drink in a day? • What else do you drink for fluids?
S3	**What do you do when you get stressed or angry?** • Go for a walk/exercise • Take a drink • Go somewhere alone • Talk to a friend/family member • Have a cigarette • Yell • Hit someone/something • Other
S4	**About how tall are you without shoes?** • Height _____ • Member refused
S5	**How much do you weigh without shoes? (Or before you were pregnant how much did you weigh?)** • Weight _____ • Member refused • Member doesn't remember *EDUCATE: If member goes <45.5kg or >91kg they become MODERATE risk & CM should provide education.*
S6	**"Many people have important beliefs about the way they care for their health. For example, some people do not eat certain kinds of food. Other people do not believe in shots. Some people go to different kinds of healers to get well." Are there any beliefs you have, cultural or spiritual, that I should know about that will help us work together better?** • None cited • Yes, describe _____ **Follow up question** (not mandatory): • Have you talked to any of your providers about these beliefs?
S7	**Do you have a written plan for health care you want if you cannot speak for yourself?** • Yes – Advance directive • Yes – Medical POA • Yes – Mental Health POA • Yes – Living Will

	• No • Don't know

6. Providers/Other Services Module

Q#	Question/Selections
P1	**"I want to understand what providers and other services that you may be using." "It looks like you have XXXX as your primary care provider" Who else do you see for your health care?** • Specialist • Counselor • Case manager • Public health clinic • Mental health center • Substance abuse provider • Other • No one **Follow up question** (not mandatory): • Tell me how well your providers work together?
P2	**Which of these providers do you see the most?** *EDUCATE: CM Instructions: Pay attention, if the provider identified here is not member's PCP. Potentially discuss w/ member.* **Follow up question** (not mandatory): • How would you rate your relationship with this doctor/counselor/nurse? • Can you talk to him/her about anything that affects your health?
P3	**What other services do you receive?** • Case management services • Chemotherapy/Radiation Therapy • Day program (i.e., adult day care) • Dialysis • Home Health Services • Homemaker services • Hospice • Meals on Wheels • Mental health services • Nutrition classes/education • Occupational therapy • Pain management • Physical therapy • Programs for children with disabilities (community or school based) • Vocational/Rehabilitative Services • Respite services • Services for the Blind • Speech and Hearing services or therapy • Substance Abuse Services • WIC • Wound care • Food stamps • Other • Not receiving other services *Instructions: CM may need to explain services. Document service information.*

	Follow up question (not mandatory): • Do your providers/other agencies work together to help you? • How well do they work together? • In general, are you able to make it to the appointments you have with this/these provider(s)?

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Appendix L

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9.16 (Q4) Sample Care Plan

Supportive Care Plan Output Letter 1
(Pages 867 – 868)

Intensive Care Plan Output Letter 2
(Pages 869 – 870)

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Address Line 1
City, State Zip

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AETNA BETTER HEALTH®

If you need this in larger print or another format, call Member Services at 1-xxx-xxx-xxxx, TTY 7-1-1.

AETNA BETTER HEALTH®

Llame hoy mismo al 1-xxx-xxx-xxxx, TTY, 7-1-1 si usted desea recibir esta carta en español.

April 06, 2015

Parent(s)/Guardian(s) of Mr. T
1st Street
City, State 00000

Care Plan for: T
Member ID #: xxxxxxxxxxx

Dear T,

Thank you for talking with me today. This plan is a summary of our discussion. Please use this list to keep track of what you do.

Together we set the following goals:

- T will learn ways to manage his condition one step at a time. By 07/03/2015

To accomplish these goals, we agreed to these actions:

What we will do?	Who will do?	By when?	Completed?
Get a prescription from the doctor for Peak Flow Meter PCP/Nurse Practitioner - JJ, MD	T, Mother	05/04/2015	Not yet started
Develop Asthma Action Plan with PCP	T, Case Manager, JJ MD (Provider), Mother	05/04/2015	Not yet started
Case Manager will give member verbal and written information on Asthma symptoms, triggers, medications & action plan	T, Case Manager, Mother	07/03/2015	In progress

We will review this care plan on or before 07/03/2015 and will update it as needed. I look forward to our continued work towards a healthier you! Please call me at **1-xxx-xxx-xxxx** (8am – 5pm) if you have questions.

Sincerely,

Address Line 1
City, State Zip

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AETNA BETTER HEALTH®

Aetna Better Health,
Tammy L Smith

Aetna Better Health Plan Case Management Team

Take this care plan to your doctor. If you have questions to ask your doctor, write them in the space below.

Questions to ask my doctor:

Address Line 1
City, State Zip

If you need this in larger print or another format, call Member Services at 1-xxx-xxx-xxxx, TTY 7-1-1.

AETNA BETTER HEALTH®

Llame hoy mismo al 1-xxx-xxx-xxxx, TTY, 7-1-1 si usted desea recibir esta carta en español.

March 23, 2015

Ms. T
1st Street
City, State 00000

Care Plan for: T
Member ID #: xxxxxxxxxxx

Dear T,

Thank you for talking with me today. This plan is a summary of our discussion. Please use this list to keep track of what you do.

Together we set the following goals:

- T will have good follow up treatment and services. By 04/22/2015
- T will learn ways to manage her condition one step at a time. By 04/22/2015

To accomplish these goals, we agreed to these actions:

What we will do?	Who will do?	By when?	Completed?
Set up appointment with/FOR prenatal care and screening for HTN OB/GYN - Dr. X	Case Manager	03/26/2015	In progress
Set up appointment with/FOR opioid addiction & depression Substance Abuse Provider/Program - Subutex Treatment Program that accepts Medicaid payment	Case Manager	03/27/2015	In progress
Set up transportation services (through benefits, support system, vouchers, etc.)	T, Case Manager	03/27/2015	Not yet started
Case Manager will give member verbal and written information onself-care activities to promote healthy pregnancy including NAS related to opioid use.	T, Case Manager	04/22/2015	In progress
Call, contact or refer community resourcesfor education & resources to promote healthy pregnancy - WIC; Quitline	T	04/22/2015	Not yet started

Address Line 1
City, State Zip

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We will review this care plan on or before 04/22/2015 and will update it as needed. I look forward to our continued work towards a healthier you! Please call me at **1-xxx-xxx-xxxx** (8am – 5pm) if you have questions.

Sincerely,
Aetna Better Health,
Tammy L Smith

Aetna Better Health Plan Case Management Team

Take this care plan to your doctor. If you have questions to ask your doctor, write them in the space below.

Questions to ask my doctor:

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Appendix M

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10.2 (Q2) Project Plan

10.2.5 Project Plan (SIM)

11.1 (Q3) Sample UM Work Plan

Quality Management Project / State Innovation Model Project Plan (Pages 873 – 875)

Quality Management and Utilization Management Work Plan Iowa (Pages 876 – 892)

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Quality Management Project Plan (revised 4/17/15)

Task Name	Start	Finish
[redacted]		

Task Name	Start	Finish

Task Name	Start	Finish
[redacted]		

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Aetna Better Health® of Iowa QAPI Work Plan

Program Initiative	Scope/Objective[1]	Goals / Benchmarks	Responsible Person(s) Department	Committee Approval	Jan[2]	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Update / Result	Barriers	Recommendations

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Aetna Better Health® of Iowa QAPI Work Plan

Program Initiative	Scope/Objective[1]	Goals / Benchmarks	Responsible Person(s) Department	Committee Approval	Jan[2]	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Update / Result	Barriers	Recommendations
[redacted]																			

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Aetna Better Health® of Iowa QAPI Work Plan

Program Initiative	Scope/Objective[1]	Goals / Benchmarks	Responsible Person(s) Department	Committee Approval	Jan[2]	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Update / Result	Barriers	Recommendations

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[redacted]																			

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Aetna Better Health® of Iowa QAPI Work Plan

Program Initiative	Scope/Objective[1]	Goals / Benchmarks	Responsible Person(s) Department	Committee Approval	Jan[2]	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Update / Result	Barriers	Recommendations
[redacted]																			

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[redacted]

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[redacted]																			

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Appendix N

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11.2 (Q8) Sample Notice of Action

Iowa Notice of Action Letter
(Pages 894 – 896)

Iowa Notice of Extension Letter
(Pages 897 – 898)

Template Notice of Action
Initial Decision Letter
(Pages 899 – 902)

Aetna Better Health of IOWA
XXXXXX
XXXXX, IA XXXXX
1-XXX-XXX-XXXX

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at 1-XXX-XXX-XXXX and someone will help you. If this notice does not tell you what you asked for, what we decided and why, please call us at1-XXX-XXX-XXXX. This notice is available in other languages and formats if you need it. Hearing impaired: 711.

Si usted no entienda esta carta o usted tiene alguna pregunta por favor de llamar al 1-XXX-XXX-XXXX. Si esta noticia no le responde a lo que usted pregunto, lo que decidimos y por que, por favor llámenos al 1-XXX-XXX-XXXX. Esta carta esta disponible en otras idiomas y formato si es que lo necesita. Impedidos del oido (TTD) : 711.

NOTICE OF ACTION

TO: [Member Name and Address] Date: [Date letter generated]

ID: [Member Medicaid ID]

FROM: Aetna Better Health

Your doctor has asked that Aetna Better Health pay for [Describe services requested and the reason for the services in easily understood language].

Our Decision

[Insert action being taken here and date effective if terminating or reducing a current service].

The Reasons For Our Decision

Facts About Your Condition or Situation that Support Our Decision

[Insert the reason for the action, which must be complete and in commonly understood language. The explanation must be both member and fact specific, describing the member's condition and the reasons supporting the Plan's decision. Cite clinical criteria used in the decision making and the State Administrative Rule or Code. If the reason for the denial is a lack of information, the missing info must be identified so the member has an opportunity to provide it.]

Your Rights if You Disagree with This Decision

If you are not happy with this decision, you can ask us to look at the decision again. This is called an appeal. You can appeal by telling us over the phone or in writing. You must call us at 1-XXX-XXX-XXXX or write us by [Calculated Date: Date of this letter plus 30 calendar days].

If you are writing your appeal, please send it to:

Aetna Better Health of Iowa
Grievance and Appeal Department
XXXXX
XXXXX, IA XXXXX

You can also see your medical records and get other information about your appeal. Before we make our decision, you can give us any information that you think will be helpful. You can ask us to set up a meeting so that you can give us the information in person, or you can give it to us in writing.

After we review your appeal, we will send you our decision in writing within 45 days of the date we received your appeal request.

If You Need a Faster Decision on Your Appeal

If you or your doctor believes that your health or ability to function will be harmed unless a decision is made in the next 3 working days, you or your doctor can ask us for a fast review by calling us and asking for an expedited appeal. If we agree to a fast review, we will decide your appeal within 3 working days. If we do not agree a fast review is needed, we will call you as soon as possible. We will also send you our decision in writing within 2 working days.

Getting Help If You Want to Appeal This Decision

You can have someone help you appeal, including but not limited to, a family member, friend, guardian, attorney, your doctor or other health care provider can appeal for you if you write to us giving them permission.

Taking More Than 30 Days to Decide Your Appeal

For all appeals, up to 14 more days may be taken to make a decision on your case. This is called an extension. If we want an extension, we will write you and tell you why it is needed and how it is helpful to you. If you want an extension, you can ask for it by writing or calling us. If an extension is given, a decision in your appeal will be made in 44 days, rather than 30 days.

Continuing Services While We Make a Decision on Your Appeal

If the services you write about in your appeal are already being given to you, but are going to be cut back or stopped, you can ask that the services continue while we make a decision. If you want those services to continue, you must say so when you appeal. You can ask by calling us at 1-XXX-XXX-XXXX or writing to us. Your services will only be continued if you appeal by [Calculated Date: Date of this letter plus 10 calendar days]. If you do not win your appeal, you may be responsible for paying for these services provided during the appeal.

If you have any questions about filing an appeal or if you need help, you can call us at 1-XXX-XXX-XXXX.

Request a Fair Hearing

If you are not happy with the appeal decision, you may ask for a State Fair Hearing. You must do this within 90 days of when you receive the appeal decision letter. **If you want your services to continue during this time, you must ask for a State Fair Hearing within 10 days of receiving the appeal decision letter**.

At the State Fair Hearing, you may represent yourself, use a lawyer or have your provider, a relative or friend speak for you. If your provider, a relative or friend speaks for you, you must give them permission in writing to do so.

You can ask for a State Fair Hearing by:

- By calling 1-515-281-3094 (TTY: 711)
- By completing the online DHS form: https://dhssecure.dhs.state.ia.us/forms/appealrequest.htm
- By writing to the Department of Human Services (DHS) at the following address:

Department of Human Services
Appeals Section
1305 E Walnut Street, 5th Floor
Des Moines, IA 50319
Phone (515) 281-3094
FAX (515) 564-4044
Email: *appeals@dhs.state.ia.us*

To find out more about State Fair Hearings, call 1-515-281-3094 (TTY: 711) or write to DHS at the above address. Once Aetna Better Health is notified of your hearing request, we will forward a copy of your file to the DHS hearing officer.

Sincerely,

Aetna Better Health Medical Director

Cc Requesting provider
Cc Servicing provider
Cc PCP

Aetna Better Health of IOWA
XXXXXX
XXXXX, IA XXXXX
1-XXX-XXX-XXXX

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at 1-XXX-XXX-XXXX and someone will help you. If this notice does not tell you what you asked for, what we decided and why, please call us at1-XXX-XXX-XXXX. This notice is available in other languages and formats if you need it. Hearing impaired: 711.

Si usted no entienda esta carta o usted tiene alguna pregunta por favor de llamar al 1-XXX-XXX-XXXX. Si esta noticia no le responde a lo que usted pregunto, lo que decidimos y por que, por favor llámenos al 1-XXX-XXX-XXXX. Esta carta esta disponible en otras idiomas y formato si es que lo necesita. Impedidos del oido (TTD) : 711.

NOTICE OF EXTENSION

TO: [Member Name and Address] Date: [Date letter generated]

ID: [Member Medicaid ID]

FROM: Aetna Better Health

Your doctor has asked that Aetna Better Health pay for [Describe services requested and the reason for the services in easily understood language].

[Include the following paragraph if the member or requesting provider has requested the extension, otherwise delete]
You or your provider requested an extension. An extension of up to 14 days has been granted.

[Include the following three paragraphs if the health plan is taking the extension, otherwise delete]
We could not complete our review within XX calendar days as we told you we would. We feel that it is in your best interest to take up to 14 more days to make a decision. We need this time so we can get more information from [insert name of requesting provider].

We need [insert what additional information is needed, e.g. notes from your doctor that tell us if you have tried Drug X before , or notes from your doctor that tell us if you have had a chest x-ray].

We will make this decision by [insert date the extension expires]. If we do not get the information from [insert name of requesting provider] then we will have to deny this request.

If you do not agree with us taking extra time to make a decision you can file an expedited grievance (complaint). You can do this by telling us over the phone or in writing. You may call us at 1-XXX-XXX-XXXX or write us at:

Aetna Better Health of Iowa
Grievance and Appeal Department
XXXXX
XXXXX, IA XXXXX

As your health plan, we can decide to take extra time if we feel it will be of help to you. We felt extra time would help us get the information needed to make a decision.

Sincerely,

Aetna Better Health of Iowa

Aetna Better Health® of Iowa
Address
City, State ZIP
1-855-xxx-xxxx

AETNA BETTER HEALTH® OF IOWA

[Date]

[Member Name]
[Address]
[Address 2] – Suppress if blank
[City, State, Zip]

Member ID: [XXXXXXXX]

Dear [Member First Name] [Member Last Name]:

Action:
This is to advise you that, after reviewing your case, we are taking the following action checked below:

____ Limiting the number of hours/days authorized for your [insert name of service] service to [insert number of hours or days] hours/days effective [effective date];

____ Reducing the [insert name of service] service you are receiving from [insert number of hours or days] hours/days to [insert number of hours or days] hours/days effective [effective date];

____ Terminating the [insert name of service] service you are receiving effective [effective date];

____ Denying your request for [insert name of service] services effective [effective date].

____ Other: [Insert description of other action taken]

Criteria governing this action:
We are relying on the following regulation and/or written criteria [insert clinical criteria used]. You or your provider may get a copy of the regulation and/or criteria used in this decision. Call us at 1-855-xxx-xxxx (TTY: 7-1-1) Monday through Friday, 8:00 a.m. to 5:00p.m.

Reason for this action:
The reason for this action is [insert denial rationale].

In taking this action, we undertook an assessment of your need for [insert name of service]. A copy of that written assessment is enclosed.

APPEAL RIGHTS

If you disagree with this decision, you (or your provider, with your written consent) have a right to appeal this action. You have a right to appeal through Aetna Better Health appeal process. **In addition**

to, or instead of, the health plan appeal process, you also have a right to request a Medicaid Fair Hearing with the State of Iowa.

Stage 1 Health Plan Appeal Process:
At the current time, you have the right to pursue an informal, internal review by us. This is called a Stage 1 Appeal. You can file a Stage 1 Appeal orally by calling us at 1-855-xxx-xxxx (TTY: 7-1-1), or by writing to us at:

Aetna Better Health of Iowa
Appeal and Grievance Department
Address
City, State ZIP
Fax: 1-xxx-xxx-xxxx

If you choose to call, we recommend that you follow your call with a written request, although this is not required. You may want to include an explanation for the reason you are appealing our decision.

If you are currently receiving these services and you file an Appeal before your services are reduced or terminated, the services will automatically continue during the time that your appeal is pending.

You have 90 calendar days from the date you receive this notice of action (see additional information in the General Appeal Process section of this letter) to request an appeal. We will decide your Stage 1 Appeal within 10 calendar days of receipt of your appeal.

If you or your treating provider believes this 10 calendar-day timeframe for resolving your appeal could harm your health, please call us at 1-855-xxx-xxxx (TTY: 7-1-1) and ask for an expedited, or fast, appeal. An expedited or fast appeal means that we will decide your Stage 1 Appeal within 72 hours of receipt.

Medicaid Fair Hearing Process:
In addition to, or instead of, the Stage 1 Appeal Process, you may also request a Medicaid Fair Hearing. If you request a Medicaid Fair Hearing, your appeal will be transferred to the Iowa Office of Administrative Law.

If you file for a Medicaid Fair Hearing, you have the right to ask that your current services continue while this appeal is pending. You have 20 calendar days from the date you receive this notice of action (see additional information in the General Appeal Process section of this letter) to send in your request for a Medicaid Fair Hearing and to request continuation of services. If you request a continuation of services while your appeal is pending and your Medicaid (Fair Hearing) appeal is denied, you may be required to pay for the cost of the services.

A Medicaid Fair Hearing must be requested in writing.

If you would like to file a Medicaid Fair Hearing, please fill out the section below and return a copy of this entire notice of action letter to:

Department of Human Services
Appeals Section
1305 E Walnut Street, 5th Floor
Des Moines, IA 50319
Phone (515) 281-3094
FAX (515) 564-4044
Email: *appeals@dhs.state.ia.us*

Your name (print) _____

Your phone #_____ Date _____

I would like to request a Medicaid Fair Hearing because: (Please state here why you disagree with the action taken above or attach a separate letter.)

_____

_____

_____

_____Check here if you would like to request a continuation of services while this appeal is pending.

You have the right to an interpreter for the Medicaid Fair Hearing. You can request an interpreter from the State. If you would like to request an interpreter from the State, check below and indicate the language you need. You may also bring a relative or friend to interpret for you. (You do not need to check the box if you will bring your own interpreter.)

_____I am requesting an interpreter for the Medicaid Fair Hearing in the following language: _____.

General Appeal Process:

Date of receipt - The date on which this notice of action is received by you is considered to be five days after the date listed at the top of this notice of action, unless you can show that you did not receive this notice of action within this five-day period.

Right to representation - You have the right to represent yourself, have someone else represent you, or have legal representation. If you would like legal representation and are not able to pay for this, you can contact one of the following:

Iowa Legal Aid at www.iowalegalaid.org or call Iowa Legal Aid at X-XXX-XXXX; or

Disability Rights Iowa at www.disabilityrightsiowa.org or call Iowa Disability Rights X-XXX-XXXX (TTY: XXX) for free legal and advocacy services for people with disabilities.

Additional help if you are LEP (Limited English Proficient) or disabled - This notice of action has been written in Spanish on the reverse side. If you need help in other languages, please see the attached Babel notice. If you are blind or otherwise disabled and need help accessing this notice, please call us at 1-855-xxx-xxxx (TTY: 7-1-1).

Sincerely,

Medical Director

cc: [Insert Provider Name]
Enclosures

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Appendix O

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12.2 Program Integrity Plan

2015 Fraud Waste and Abuse Plan
(Pages 905 - 912)

2015 Medicaid Compliance Plan
(Pages 913 - 928)

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2015 Fraud Plan

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Aetna
2015 Fraud Program

I. Adoption of 2015 Fraud Plan (the "Plan")

This Plan has been adopted by Aetna Better Health, and is intended to help ensure compliance with federal and state laws, rules and regulations applicable to all Aetna Better Health programs. The Compliance Manager will review this Plan at least annually, or more frequently as necessary, to incorporate required revisions. Changes will be provided to the Board of Directors (BOD) and/or the Quality Management Oversight Committee (QMOC) for adoption. The BOD has ultimate authority over compliance within Aetna Better Health.

With respect to Medicaid and CHIP plans, two federal agencies have issued guidance regarding fraud programs: the Centers for Medicare & Medicare Services (CMS) and the Office of Inspector General (OIG). The fraud plan requirements are contained in 42 C.F.R. §§455.2. In general, the CMS regulations require that Medicaid fraud plans include a comprehensive fraud and abuse plan to detect, correct, and prevent fraud, waste, and abuse. The Fraud plan must meet the requirements of §§455.13 through 455.23: (1) methods for identification, investigation and referral, (2) preliminary investigation, (3) full investigation, (4) resolution of full investigation, (5) reporting requirements, (6) provider's statement on claims forms, (7) provider's statement on check, (8) Recipient verification procedure, (9) cooperation with State Medicaid fraud control units, (10) withholding of payment in cases of fraud or willful misrepresentation. Additional federal and state laws and regulations may apply.

Aetna Better Health does not tolerate retribution, retaliation or adverse personnel action of any kind including but not limited to discharge, demotion, suspension, threats, harassment, or any other manner of discrimination against an employee or the terms and conditions of an employee's employment for lawfully reporting a situation of potential fraud, waste or abuse or providing to the company or any law enforcement or other governmental agency any information or assistance relating to the commission or possible commission of any federal or state offense or for taking any lawful action in accordance with Section 3730(h) of Title 31 of the United States Code ("USC") on behalf of the employee or others in furtherance of an action under Title 31 of the USC (31 USC 3729) including investigation for, initiation of an action regarding, testimony for, or assistance in any false claims action filed or to be filed under 31 USC 3730. In the event of any retribution, retaliation or adverse personnel action of any kind with respect to an action under 31 USC 3729, the employee shall be entitled to all relief necessary to make the employee whole. (See 31 USC 3730(h) (Whistleblower Protections))

The Aetna Better Health Fraud Plan and Program is intended to fulfill the obligations specified in CMS and state laws and regulations and OIG guidance.

II. Statement of Policy

It is the policy of Aetna Better Health, as set forth in the Aetna Code of Conduct [Attachment 1], that business shall be conducted in strict compliance with laws, regulations and high ethical standards. Deviations from such standards constitute a violation of Aetna policy. Aetna has established and maintains effective compliance and other programs for the purpose of preventing, detecting, and correcting illegal, improper and unethical conduct, including insurance fraud.

It is the policy of Aetna Better Health to consistently respond to referrals requiring investigation in a manner that promotes a basis for halting losses to the company and our customers, and initiating corrective action where appropriate. Referrals to law enforcement for prosecutions will be initiated when practical, and recoveries obtained when possible. Aetna Better Health will advise state regulators of all referrals as required.

III. Definitions

In accordance with section 455.2 of Title 42 of the Code of Federal Regulations (42 CFR 455.2), fraud and abuse are defined as follows.

- Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
- Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Although not formally defined in federal regulations, waste can be defined as follows:

- Waste: Treatment or services that are unnecessary, redundant, or ineffective and are contrary to, or not demonstrably associated with, health care quality and outcomes and may result in unnecessary costs.

State definitions of fraud, waste or abuse may differ from the definitions set forth above; therefore Aetna Better Health must identify and abide by any differences.

IV. Procedures

Aetna Better Health, in coordination with the Special Investigations Unit (SIU), and in consultation with legal counsel, will be responsible as applicable for the following[1] :

1. Assuring availability of avenues for employees, providers or members to report fraud, waste or abuse.
2. Participate in external investigations related to healthcare fraud, waste and abuse as appropriate.
3. Attempt to recover financial losses attributable to healthcare fraud and abuse.
4. Investigate violations of the Unfair Claim Practices Act.
5. Evaluate and respond to any subpoenas related to health care fraud and abuse.
6. File mandated anti-fraud plans and required reports.
7. Report to various state agencies, as required by law and/or contract, on healthcare fraud and abuse investigations.
8. Provide educational programs to Aetna Better Health employees to aid in deterring and minimizing healthcare fraud, waste and abuse losses.
9. Communicate to Aetna Better Health leadership any business controls in need of strengthening.
10. Refer cases to law enforcement for prosecution as appropriate.
11. Refer cases to Provider Relations and/or Credentialing with respect to continued network participation or proper claim submission education.
12. Refer cases to Quality Management with respect to potential quality of care issues.
13. Refer cases to legal counsel with respect to potential legal action regarding providers or members as appropriate.

V. Identification of Suspected Fraud, Waste or Abuse

Incoming Referrals

Incoming referrals can be received from but are not limited to the following sources:

- Aetna Better Health Online Health Care Fraud form. [Attachment 2]
- Aetna Better Health or Medicaid hotlines/websites set up for the purpose of reporting fraud
- State, Federal or other agency referral
- Local media reports that highlight cases of fraud
- Reports from subcontracted vendors
- Member and provider inquiries
- Verbal reports to the Aetna Better Health Compliance Manager

1 The plan shall identify the steps to be taken and include a timeline with target dates upon release of the reporting manual.

Upon receipt of a referral, appropriate investigation will be conducted as described in this plan.

Additional methods to detect fraud, waste and abuse include but are not limited to:

- Utilization review (include under or over utilization as applicable)
- Prior authorization
- Training and education follow-up
- Claims software that identifies claims discrepancies at the time of adjudication
- Review and/or trending of claims
- Claims software that identifies claims discrepancies post adjudication)
- Review and/or trending of grievance and appeals

Any potential fraud, waste or abuse identified via these methods is then routed through the process described in this plan.

VI. Investigation and Analysis

The steps listed below will be followed in the course of a typical Health Care Fraud or Abuse Investigation. While each case will differ, Aetna Better Health staff will follow the basic process outlined below to ensure a complete and consistent investigation of allegations.

When the case is received, the following steps may occur:

1) Perform an initial review of the referral
2) Document the referral in a tracking system
3) Refer to SIU as appropriate
4) Refer the [allegation or confirmed case depending on state requirements] to state/federal agencies as required within the prescribed timeframe

In cases where a review of medical records is required to fully investigate the allegations, the SIU investigator will coordinate with the Aetna Better Health Compliance Manager.

1) Verification of service(s) letters will be sent to members, providers or other agencies.
2) Plan will use approved letter templates to the extent required by the State.
3) Letters will include Aetna Better Health logo on the stationary
4) Medical records will be returned to the SIU investigator for review. The SIU may coordinate with the Aetna Better Health medical director or other appropriate staff as part of the review.

The SIU utilizes IBM's Fraud and Abuse Management System (FAMS) to analyze claims data. The data can be grouped by Health Plan, provider specialty and geographic area to

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identify outlier billing trends that may require further review. FAMS can be customized to run Medicaid specific reports, and can be mapped to specific Medicaid Plans for analysis.

When the review of evidence indicates a pattern of discrepant behavior on a provider case, the SIU investigator will contact the Aetna Better Health Compliance Manager to request approval to add a fraud flag and prepare a discrepancy notification letter to the provider. As required, the Aetna Better Health Compliance Manager will [notify or obtain approval from] the state of these actions.

For cases of potential member fraud, a notation will be placed in the member's record in QNXT (the Medicaid operating system), Aetna Better Health will take any additional steps as required by the contract and/or state and federal regulations and will refer the case to the State, as required, for further action.

Recovery of funds lost to fraudulent or abusive behavior will be pursued until all avenues for reimbursement have been exhausted. The Compliance Manager will coordinate with provider relations and the claims department as necessary regarding recovery of these funds.

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APPENDIX A:

Summary of Relevant Federal Laws - from 3000.40 Deficit Reduction Act and False Claims Act Compliance Requirements

Federal False Claims Act (31 U.S.C. §§ 3729-3733):

Under the False Claims Act a person or organization is liable for:

- Knowingly presenting or causing to be presented a false or fraudulent claim for payment or approval;
- Knowingly making, using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved;
- Conspiring to defraud by getting a false or fraudulent claim allowed or paid;
- Delivering or causing to be delivered less property than the amount for which the person receives a certificate or receipt;
- With intent to defraud, making or delivering a receipt without completely knowing that the information on the receipt is true;
- Knowingly buying public property from a government employee who does not have the legal right to sell the property; and
- Knowingly making or using a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government

Civil Money Penalties for False Claims in Federal Health Care Programs (42 U.S.C. §§ 1320a-7a)("CMPL"):

Provides for monetary penalties against anyone who presents a claim to a Federal or state officer, employee or agency that he or she knows or should have known was not provided as claimed. CMPL can also be imposed on a provider who: 1) submits a bill for services provided by a person who is not licensed or is excluded from Federal or state health care programs; 2) violates the anti-kickback statute, or 3) violates the prohibition on physician self-referral, or Stark, law.

Criminal Penalties for False Claims in Federal Health Care Programs (42 U.S.C. § 1320a-7b):

A fine of up to $25,000.00 and/or imprisonment of up to five years may be imposed on any person in connection with the furnishing items of services under a Federal health care program and who is convicted of a felony for knowingly and willfully:

- Making a false statement or representation of material fact in any application for a benefit or payment under or for use in determining rights to such benefit or payment in a Federal health care program;
- Concealing or failing to disclose, with intent to defraud, any event affecting his or her initial or continued right to any benefit or payment;

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- Presenting or causing to be presented a claim for a provider's service for which payment may be made under a Federal health care program and knowing that the individual who furnished the service was not a licensed provider; or
- For a fee counseling or assisting an individual to dispose of assets in order for the individual to become eligible for medical assistance under a state Medicaid program if disposing of the assets results in the imposition of a period of ineligibility for such assistance

Federal Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b)):

The anti-kickback statute was designed to prevent fraud and abuse in Federal health care programs by making it a crime for anyone to knowingly and willfully solicits or receives, or pays anything of value (remuneration) including any kickback, bribe, or rebate in return for referring an individual to a person for any item or service for which payment may be made in whole or in part under a Federal health care program. Punishment for felony conviction for violating the anti-kickback law is a fine of not more than $25,000 or imprisoned for not more than five years, or both, administrative civil money penalties of up to $50,000.00, and exclusion from the Federal health care programs. The law contains several "safe harbors" that provide protection from prosecution for certain transactions and business practices with further guidelines provided in 42 C.F.R. § 1001.952.

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2015
AETNA MEDICAID COMPLIANCE PLAN

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Last Revised: January 2015

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Section 8 Procedures and System for Prompt Response to Compliance Issues

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Section 1

Introduction

The Aetna Medicaid Compliance Plan is an overview of the Aetna Medicaid Compliance Program. The Medicaid Compliance Program is designed to prevent, detect and correct non-compliant operational practices and improper or unethical conduct impacting Aetna Medicaid plans. It is further designed to detect, prevent and correct incidents of Medicaid fraud, waste and abuse (FWA). The Program is based on the 7 Elements of an Effective Compliance Program, as outlined in OIG Compliance Program Guidance.

It is the policy of Aetna, as set forth in the Aetna Code of Conduct, that all business lines, including all Medicaid plans and products, shall be conducted based on the highest ethical standards and in strict compliance with applicable federal and state laws and regulations.

1. Prohibited Affiliations

Prohibited affiliations with individuals, owners and managing employees is a key component of assuring that Aetna makes no payments for Medicaid services to any individual or entity debarred by any federal agency. Aetna will terminate the participation of any individual or entity found to be excluded, debarred, suspended or terminated by a federal or state health care program.

2. Program Integrity – Fraud, Waste and Abuse

Aetna is committed to maintaining a comprehensive plan to detect, correct and prevent fraud, waste and abuse ("FWA"). The Aetna Medicaid Special Investigations Unit ("SIU") is responsible for the Plan. The SIU staff investigates potential FWA and works with appropriate Aetna staff, vendors, and government and law enforcement agencies when dealing with health care FWA.

3. Fraud, Waste and Abuse Laws

Aetna is committed to complying with all applicable federal and state laws, regulations and other requirements pertaining to FWA. Aetna will not tolerate health care FWA in any of its relationships with internal and external parties. Aetna will identify, report, monitor, and when appropriate, refer for prosecution, situations in which suspected fraud or abuse occurs.

There are numerous laws, both federal and state, that address health care fraud. These laws define fraud and establish the framework for prosecuting criminal acts and the initiation of civil proceedings. Some of those laws are described below.

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Federal False Claims Act

The Federal Civil False Claims Act prohibits knowingly submitting, or causing to be submitted, or conspiring to submit, a false or fraudulent claim for payment or approval by the government or the use of a false record or statement in support of a claim for government payment, or concealing, avoiding or reducing an obligation to pay or transmit money or property to the government. 'Knowingly' can include deliberate ignorance or reckless disregard of facts that make the claim false and requires no proof of a specific intent to defraud. Violators are liable for three times the government's damages plus civil monetary penalties of $5,500 to $11,000 per false claim. Many states also have their own FWA provisions.

Whistleblower Protection

The whistleblower provisions of the Federal False Claims Act protect employees who report suspected misconduct and/or assist in investigations or prosecution. Employees are made aware of these protections through the Aetna Code of Conduct.

Anti-Kickback Statute

The Federal Anti-Kickback Statute prohibits knowingly or willingly offering, paying, soliciting, or receiving anything of value to induce referrals of items or services payable by a federal health care program. Violations are considered felonies, punishable by criminal fines and imprisonment. A violation may also lead to the imposition of civil monetary penalties and possible exclusion from participation in federal health care programs. Many states also have their own anti-kickback laws. These laws can vary widely and, in contrast to the federal statute, may not be restricted to federal health care programs.

Health Information Portability and Accountability Act of 1996 ("HIPAA")

HIPAA established, among other things, standards for certain electronic transactions and minimum privacy and security requirements for individually identifiable health information. The protection of individual information may reduce chances of misuse of the information for fraudulent purposes and may reduce the risk of identity theft.

Aetna maintains written policies regarding compliance with specific federal and state fraud, waste and abuse laws. These policies are available to all employees through the company intranet.

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Aetna Medicaid Compliance - Vision, Mission and Strategy

Vision:

To inspire and empower every Aetna Medicaid employee to always adhere to the Aetna Values: do the right thing, the right way and for the right reason.

Mission:

To deliver a world class Medicaid compliance program that provides value to our customers. We will accomplish this mission by developing proactive monitoring and tracking systems designed to prevent, detect and correct conduct that violates the law or Aetna's value system. In doing so, we will give all Aetna Medicaid employees the ability to achieve success while adhering to Aetna's high ethical standards.

Medicaid Compliance Strategy:

Medicaid Compliance will realize its vision and satisfy its mission by following these strategies:

1. STAFFING AND GOVERNANCE. Create an environment that encourages collaboration and cross-training. Establish and maintain an effective system for resolving and escalating issues.

2. POLICIES, PROCEDURES & CODE OF CONDUCT. Maintain clear policies and procedures that address the risks. Maintain a Code of Conduct to inform all employees on their responsibilities. Develop oversight and monitoring programs to ensure employees adhere to Aetna Medicaid's policies, procedures and Code of Conduct.

3. EFFECTIVE TRAINING & EDUCATION. Create and deliver effective and meaningful training programs to all employees about the compliance responsibilities related to their jobs.

4. COMMUNICATION. Strengthen our Aetna Medicaid culture by communicating Aetna's values and policies in a targeted and meaningful way that engages all Aetna employees.

5. EFFECTIVE SYSTEM FOR ROUTINE MONITORING AND IDENTIFICATION OF RISK. Establish and maintain easily accessible systems for employees to interact with Medicaid Compliance and management so that they can ask questions and raise concerns. Develop and coordinate with Internal Audit a Compliance Monitoring Plan to review key business activities and to ensure they are being conducted in accordance with the law and Aetna policies, procedures and Code of Conduct.

6. EFFECTIVELY PUBLICIZE DISCIPLINARY STANDARDS. Publish disciplinary standards and Aetna's Code of Conduct on the Aetna Medicaid Internal "Hub" site and on the Compliance & Regulatory Affairs home page. Continue to communicate standards during town hall and team

meetings.

7. PROCEDURES AND SYSTEMS FOR PROMPT REPORTING. Maintain and communicate clear, objective and efficient systems, training and tools for the investigation of alleged compliance violations. Ensure fair and consistent discipline for compliance violations.

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Section 2

Written Policies, Procedures and Standards of Conduct

I. Commitment to Compliance with Federal and State Standards and the Compliance Expectations Embodied in the Aetna Code of Conduct

Aetna, including Aetna's Medicaid Program, is committed to complying with all applicable federal and state laws and regulations, and committed to the highest ethical standards. Aetna employees are required to attest, on an annual basis, to the Aetna Code of Conduct (www.aetna.com/investors-aetna/governance/code_of_conduct.html).

II. Policies Implementing Compliance Program

The policies and procedures that define our Medicaid Compliance Program are available on the Aetna internal website--the Medicaid "Hub". Medicaid Compliance maintains a list of the most current policies and procedures for our Compliance Program on the "Hub" site. We maintain policies on the "Hub" to ensure that our policies and procedures are as accessible as possible, both within our department and for our business partners.

III. Identifying How to Communicate Compliance Issues

Please refer to "Section 8: Procedures and System for Prompt Response to Compliance Issues" for more information on raising compliance concerns, including escalation of compliance concerns, investigation and resolution of compliance issues, and non-retaliation assurance.

IV. Describing How Compliance Issues are Investigated and Resolved

Please refer to "Section 8: Procedures and System for Prompt Response to Compliance Issues" for more information on raising compliance concerns, including escalation of compliance concerns, investigation and resolution of compliance issues, and non-retaliation assurance.

V. Policy of Non-Retaliation

Please refer to "Section 8: Procedures and System for Prompt Response to Compliance Issues" for more information on raising compliance concerns, including escalation of compliance concerns, investigation and resolution of compliance issues, and non-retaliation assurance.

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VI. Governing Body Approval of Compliance Policies and Procedures and Standards of Conduct.

Please refer to "Section 3: Compliance Officer, Compliance Committee and High Level Oversight".

VII. Distribution of Compliance Policies and Procedures and Standards of Conduct.

As referenced in section 2, item II, Compliance Policies and Procedures can be found on the Medicaid Compliance site on The "Hub". The Aetna Code of Conduct is also readily available on our external Aetna website.

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Section 3

Compliance Officer, Compliance Committee and High Level Oversight

I. Compliance Officer Duties: The Chief Medicaid Compliance Officer (CMCO) is responsible for:
   a. Regularly creating and delivering reports related to compliance matters.
   b. Hosting ongoing, periodic and scheduled meetings with Aetna Medicaid business leaders.
   c. Collaborating on the creation of Medicaid specific compliance and Fraud Waste and Abuse (FWA) training and policies for officers, directors, managers, and employees.
   d. Increasing, through education and other activities, the reporting of Medicaid program non-compliance and suspected non-compliance by employees and others.
   e. Coordinating responses to FWA, non-compliance incidents within Aetna (e.g., Aetna's Medicaid Special Investigation Unit ("SIU")) and with external parties.
   f. Overseeing the development, monitoring and implementation of internal and external Corrective Action Plans (CAPs).
   g. Overseeing the completion of a Medicaid enterprise compliance risk assessment annually.

II. Compliance Committee and High Level Oversight
   a. The Executive Medicaid Compliance Steering Committee is comprised of senior leadership from a variety of Aetna business units.
   b. As the name suggests, the Executive Medicaid Compliance Steering Committee oversees the overall Medicaid program, and ensures, among other things, a "top down" commitment to compliance.

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Section 4

Effective Training and Education

I. General Compliance Training

a. All Aetna employees who work with Medicaid are required to take, as a condition of their employment, Medicaid Compliance and Fraud, Waste and Abuse training upon hire and annually thereafter.
b. Medicaid Compliance and FWA training are updated at least annually.
c. In addition, as a further condition of employment, all Aetna employees are required to take Aetna's Business Conduct and Integrity training upon hire and annually thereafter.
d. Training is considered complete when a "knowledge test" has been completed and passed (a score of 90% is considered passing). Completion is tracked through our Aetna Learning and Performance technology. Records of training completion are kept. Failure to complete training results in escalation to increasingly higher levels of management.

II. Specialized Training

The Medicaid Compliance team, working independently or in collaboration with their business colleagues, creates and conducts specialized training on a regular basis throughout the year.

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Section 5

Effective Lines of Communication

I. Establishing Mechanisms to Ensure Internal Communication of Compliance-Related Matters

a. Compliance issues (and trends in compliance issues) are communicated to our partners in other Aetna Medicaid business segments through:
   - Medicaid Executive Compliance Steering Committee Meetings
   - Plan-based Compliance Committees
   - Meetings between CMCO and senior Medicaid leaders
   - Training
   - Media (e.g., posters, the "Hub" site, etc.)

II. Establishing a Mechanism to Field Compliance Questions and Concerns from Employees and other parties

a. On a corporate level, Aetna uses AlertLine to receive, track and respond to reports of potential non-compliance or FWA. Through AlertLine, employees and other parties may report concerns anonymously. This can happen through the AlertLine phone or their website. Each method for reporting is designed to be anonymous. All investigations are turned over to Aetna's Chief Compliance and Ethics Officer, who assigns Medicaid-related complaints to the Chief Medicaid Compliance Officer or the SIU.

b. On a local level, plan-based hotlines (if contractually required) are available to receive reports. Plan-based compliance team members track, triage, investigate as necessary, and manage reports.

III. Member Communications and Education

a. The Aetna Code of Conduct is widely available externally to our members via Aetna's website.

b. Aetna periodically communicates information on FWA to our members.

IV. Well-Publicized Disciplinary Standards

Please refer to "Section 6: Well Publicized Disciplinary Standards" for more information on our disciplinary policy for instances of non-compliance.

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Section 6

Well-Publicized Disciplinary Standards

I. Disciplinary Standards

a. The Aetna Code of Conduct explains to all employees that disciplinary action will be taken, up to and including (but not limited to) termination, for:
   - Failure to follow the Aetna Code of Conduct or other Aetna policies.
   - Breaking any laws or regulations that apply to Aetna.
   - Telling an employee to violate the Code of Conduct, an Aetna policy, a law or a regulation.
   - Failing to share information, or providing false information in connection with an investigation, about a violation of the Code of Conduct, a law or a regulation.
   - Retaliation against another employee who, in good faith, reports a suspected violation or who cooperates or helps with an investigation.
   - Neglecting to address or report a violation of the Code of Conduct, or a law or regulation, committed by someone you manage.

b. The Chief Medicaid Compliance Officer will elevate to and work closely with Aetna's Chief Compliance and Ethics Officer or designee when functional business areas fail to resolve non-compliant activities to determine if disciplinary action is appropriate. Disciplinary action takes place in a variety of ways, including (but not limited to):
   - Coaching;
   - Refresher Training;
   - Policy Reminder & Notice;
   - One-Time Warning;
   - Suspension Without Pay;
   - Financial Consequences
   - Reporting relationship change or transfer to another position;
   - Notification to external entities such as law enforcement/regulatory agencies and licensing boards; and
   - Termination of employment.

II. Methods to Publicize Disciplinary Standards

a. Disciplinary standards are published in Aetna's Code of Conduct.
   Reference to Aetna Code of Conduct, policies in AccessHR

III. Enforcing Disciplinary Standards

a. Our methods for communicating non-compliant business practices to the Business include (but are not limited to) the following:
   - Verbal and/or written consultations
   - Internal Notices of Non-Compliance
   - Requests for Corrective Action Plans

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- Mandatory Management Action Plans (issued in conjunction with an internal audit receiving a "High Priority" result)

b. Our methods for communicating non-compliant behavior by an employee include:
   - Verbal Notice
   - Written Notice
   - Performance Improvement Action Plan, and other disciplinary action up to and including termination

c. Should communication of the problem by Medicaid Compliance staff fail to stimulate sufficient action, the CMCO has the authority to continue to escalate the issue and to recommend an increase to the severity of the disciplinary action.

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Section 7

Effective System for Routine Monitoring and Identification of Compliance Risks

I. Compliance Work Plan Development
   a. On an annual basis, the Medicaid Compliance team conducts a risk assessment overseen by the CMCO. This assessment is designed to review and rank the key regulatory risks the coming year poses to each business area.
   b. In response to this risk assessment, a compliance work plan is developed.
   c. The compliance work plan includes monitoring plans and any assessments to be performed.
   d. Medicaid Compliance is responsible for managing and completing the work plan.

II. Internal Risk Assessment Process
   a. Each Medicaid Plan Compliance Officer is responsible for rating the compliance risks associated with his or her assigned plan.

III. Relationships
   a. Aetna's Internal Audit group may audit any system, process or department at Aetna, including any Medicaid system, process or department. Aetna Medicaid Compliance engages Internal Audit regularly to assess progress and coordinate plans.
   b. Aetna's SIU is charged with reducing health care fraud, waste and abuse and detecting and preventing illegal activities.

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Section 8

Procedures and System for Prompt Response to Compliance Issues

When a possible instance of non-compliance is detected, whether discovered internally or externally, Aetna's Medicaid Compliance team takes appropriate action to investigate, correct and implement steps to prevent recurrence. Aetna is committed to prompt reporting of compliance issues. As outlined in Section 5: Effective Lines of Communication, there are a number of channels through which an instance of non-compliance might be raised for inquiry. Once the CMCO (or the CMCO's designee) has been informed, the inquiry and investigation stage begins.

I. Conducting a Timely and Reasonable Inquiry of Detected Offenses
Compliance investigations are considered a priority of the CMCO. The CMCO may delegate duties associated with the investigation, as needed.

II. Aetna prohibits retaliating against anyone who in good faith:
a. Makes a complaint or reports a violation to Aetna or any law enforcement or government agency.
b. Collaborates or helps with a government or internal investigation.
c. Provides information to the government or Aetna about a breach of law or Aetna policy.

III. Corrective Actions
As referenced in Section 6, item III, when there are confirmed instances of non-compliance, the response depends upon the severity of non-compliance. The CMCO has the authority to escalate the corrective action, including personnel action, to senior leadership for immediate action.

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Appendix P

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13.1 (Q4) Draft Information System Plan
(Pages 930 - 938)

13.1 (Q11) Sample Release Management Plan
(Pages 930 - 938)

13.1(Q10) System Resolution Plan
(Pages 940)

Duals Plan and IT Dashboard /SUMMARY

SUMMARY

RELEASE	Not Started	On Track	Risk Potential	At Risk	Completed	Out of Scope/No IT Impact	On Hold	Business Need Date	Blocked/Risks/Dependencies
CONNECTIVITY & PROCESSES	6	0	0	0	0	0	0		
QNXT SETUP	3	0	0	0	0	0	0		
RELEASE 1	12	0	0	0	0	0	0		
RELEASE 2	14	0	0	0	0	0	0		
RELEASE 3	46	0	0	0	0	0	0		
RELEASE 4	11	0	0	0	0	0	0		
TOTAL	**83**	**0**	**0**	**0**	**0**	**0**	**0**		

RELEASE	Requirements	Development	Testing
CONNECTIVITY & PROCESSES	0%	0%	0%
QNXT SETUP	0%	0%	0%
RELEASE 1	0%	0%	0%
RELEASE 2	0%	0%	0%
RELEASE 3	0%	0%	0%
RELEASE 4	0%	0%	0%
Release Summary	**0%**	**0%**	**0%**
Project Summary	**0%**		
RELEASE 3 - CSS	0%	0%	0%

Duals Plan and IT Dashboard /Connectivity and Processes

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Task Status	Task Name	Req End Date	Req % complete	Set up End Date	% Complete	QA End Date	QA % complete	UAT End Date	Depl. Date	Business Resources	Blocked Requirements	Status/Remarks
Not Started	Connectivity with Emdeon	10/01/2015	0%	10/08/2015	0%	10/15/2015	0%	10/22/2015	10/25/2015			
Not Started	Connectivity with State - Enrollment	10/01/2015	0%	10/08/2015	0%	10/15/2015	0%	10/22/2015	10/25/2015			
Not Started	Connectivity with State - Encounters	10/01/2015	0%	10/08/2015	0%	10/15/2015	0%	10/22/2015	10/25/2015			
Not Started	837 File Exchange Process (includes set up with EDI Gateway) with Emdeon	10/01/2015	0%	10/08/2015	0%	10/15/2015	0%	10/22/2015	10/25/2015			
Not Started	Vendor Connectivity - (Vision)	10/01/2015	0%	10/08/2015	0%	10/15/2015	0%	10/22/2015	10/25/2015			
Not Started	Vendor Connectivity - (Dental)	10/01/2015	0%	10/08/2015	0%	10/15/2015	0%	10/22/2015	10/25/2015			
Not Started	Vendor Connectivity - (Transportation)	10/01/2015	0%	10/08/2015	0%	10/15/2015	0%	10/22/2015	10/25/2015			

Duals Plan and IT Dashboard /QNXT Setup

Iowa **QNXT**

Status	Task Name	Design	% Complete	Dev Env	% Complete	QA Env	% Complete	Production Date	Business Resources	Dependency	Status/Remarks
	QNXT										
Not Started	Eligibility Design/Org Policy Structure & Mapping document for Enrollment to prepare Benefits Crosswalk	11/01/2015	0%	11/06/2015	0%	11/13/2015	0%	11/27/2015			
Not Started	QNXT Claims Benefits Configuration (#40-50)	11/01/2015	0%	11/06/2015	0%	11/13/2015	0%	11/27/2015			
Not Started	QNXT Provider & Contract Configuration	11/01/2015	0%	11/06/2015	0%	11/13/2015	0%	11/27/2015			

Duals Plan and IT Dashboard /Release 1

Iowa **Release 1**

Status	Task Name	Business Need Date	Req End Date	Req % complete	Dev End Date	Dev % Complete	QA End Date	QA % complete	UAT End Date	Depl. Date	Deployment Requirements	Business Resources	Blocked Items	Status/Remarks	BA
	Release 1 - Provider Files														
Not Started	State Provider File (O) (Provider Registry File)	11/01/2015	08/31/2015	0%	09/28/2015	0%	10/12/2015	0%	10/26/2015	10/30/2015	DBA task (24 hours)				
Not Started	State Provider File (O) (Provider Registry Site File)	11/01/2015	08/31/2015	0%	09/28/2015	0%	10/12/2015	0%	10/26/2015	10/30/2015	DBA task (24 hours)				
Not Started	State Provider File (O) (Primary Care Physician (PCP) Linkage Directory)	11/01/2015	08/31/2015	0%	09/28/2015	0%	10/12/2015	0%	10/26/2015	10/30/2015	DBA task (24 hours)				
Not Started	State Provider File (I) (Provider Registry Edit File)	11/01/2015	08/31/2015	0%	09/28/2015	0%	10/12/2015	0%	10/26/2015	10/30/2015	DBA task (24 hours)				
Not Started	State Provider File (I) (Provider Registry Site - Error File)	11/01/2015	08/31/2015	0%	09/28/2015	0%	10/12/2015	0%	10/26/2015	10/30/2015	DBA task (24 hours)				
Not Started	State Provider File (I) (Primary Care Physician (PCP) Linkage Error File)	11/01/2015	08/31/2015	0%	09/28/2015	0%	10/12/2015	0%	10/26/2015	10/30/2015	DBA task (24 hours)				
Not Started	State Provider File (O) (Provider Supplemental Record File) - Weekly & Monthly	11/01/2015	08/31/2015	0%	09/28/2015	0%	10/12/2015	0%	10/26/2015	10/30/2015	DBA task (24 hours)				
Not Started	Vision Provider File (I)	11/01/2015	08/31/2015	0%	09/28/2015	0%	10/12/2015	0%	10/26/2015	10/30/2015	DBA task (24 hours)				
Not Started	Provider File (O)	11/01/2015	08/31/2015	0%	09/28/2015	0%	10/12/2015	0%	10/26/2015	10/30/2015	DBA task (24 hours)				
Not Started	Dental Provider File (I)	11/01/2015	08/31/2015	0%	09/28/2015	0%	10/12/2015	0%	10/26/2015	10/30/2015	DBA task (24 hours)				
Not Started	Pharmacy Provider File (I)	11/01/2015	08/31/2015	0%	09/28/2015	0%	10/12/2015	0%	10/26/2015	10/30/2015	DBA task (24 hours)				
Not Started	Provider File (O), Passthrough to Pharmacy with masking SSN - Layout same as Provider File (I)	11/01/2015	08/31/2015	0%	09/28/2015	0%	10/12/2015	0%	10/26/2015	10/30/2015	DBA task (24 hours)				

Duals Plan and IT Dashboard /Release 2

Iowa **Release 2**

Task Status	Task Name	Business Need Date	Req End Date	Req % complete	Dev End Date	Dev % Complete	QA End Date	QA % complete	UAT End Date	Depl. Date	Deployment Requirements	Business Resources	Blocked Requirements	Status/Remarks	BA
	Release 2 - Eligibility Readiness (Enrollment)														
	Member Applications														
Not Started	ID Cards	12/10/2015	09/24/2015	0%	10/29/2015	0%	11/19/2015	0%	11/27/2015	12/04/2015	DBA task (24 hours)				
Not Started	Welcome Kit	12/10/2015	09/24/2015	0%	10/29/2015	0%	11/19/2015	0%	11/27/2015	12/04/2015	DBA task (24 hours)				
Not Started	Enrollment Manager: Job Manager, File Loader and Daily	12/10/2015	09/24/2015	0%	10/29/2015	0%	11/19/2015	0%	11/30/2015	12/04/2015	Enterprise CRQs - incl. AQMS (5 days) + DBA tasks				
Not Started	Enrollment Manager: Recon	12/10/2015	09/24/2015	0%	10/29/2015	0%	11/19/2015	0%	11/30/2015	12/04/2015	Enterprise CRQs - incl. AQMS (5 days) + DBA tasks				
Not Started	Enrollment Manager - PCP Information	12/10/2015	09/24/2015	0%	10/29/2015	0%	11/19/2015	0%	11/30/2015	12/04/2015	Enterprise CRQs - incl. AQMS (5 days) + DBA tasks				
Not Started	Enrollment Manager COB	12/10/2015	09/24/2015	0%	10/29/2015	0%	11/19/2015	0%	11/30/2015	12/04/2015	Enterprise CRQs - incl. AQMS (5 days) + DBA tasks				
Not Started	Enrollment Manager LAHIPP	12/10/2015	09/24/2015	0%	10/29/2015	0%	11/19/2015	0%	11/30/2015	12/04/2015	NA				
Not Started	834- Test File from State	12/10/2015	09/24/2015	0%	10/29/2015	0%	11/19/2015	0%	11/30/2015	12/04/2015	NA				
	Vendor Eligibility Exports														
Not Started	Pharmacy Eligibility File	12/10/2015	09/24/2015	0%	10/29/2015	0%	11/19/2015	0%	11/30/2015	12/04/2015	Enterprise CRQs (5 days) + DBA tasks				
Not Started	Pharmacy Smart Edits	12/10/2015	09/24/2015	0%	10/29/2015	0%	11/19/2015	0%	11/30/2015	12/04/2015	Enterprise CRQs (5 days) + DBA tasks				
Not Started	DentaQuest (Dental)	12/10/2015	09/24/2015	0%	10/29/2015	0%	11/19/2015	0%	11/30/2015	12/04/2015	Enterprise CRQs (5 days) + DBA tasks				
Not Started	Quest (Lab)	12/10/2015	09/24/2015	0%	10/29/2015	0%	11/19/2015	0%	11/30/2015	12/04/2015	Enterprise CRQs (5 days) + DBA tasks				
Not Started	Block Vision (Vision)	12/10/2015	09/24/2015	0%	10/29/2015	0%	11/19/2015	0%	11/30/2015	12/04/2015	Enterprise CRQs (5 days) + DBA tasks				
Not Started	Logisticare (Transportation)	12/10/2015	09/24/2015	0%	10/29/2015	0%	11/19/2015	0%	11/30/2015	12/04/2015	Enterprise CRQs (5 days) + DBA tasks				

Duals Plan and IT Dashboard /Release 3

Iowa **Release 3**

`	Task Name	Business Need Date	Req End Date	Req % complete	Dev End Date	Dev % Complete	QA End Date	QA % complete	UAT End Date	Depl. Date	Deployment Req	Business Resources	Blocked Requirements/Dependencies	Status/Remarks	BA
	Release 3 - Go-Live (Membership Effective) - (02/01/2015)														
	Marketing														
Not Started	Website (CMS and Sitewire's Ecosystem) configuration & deployment	12/24/2015	09/24/2015	0%	11/19/2015	0%	11/26/2015	0%	12/10/2015	12/20/2015	Enterprise CRQs (5 days) + DBA tasks				
Not Started	Web Provider Search + Fraud & Abuse + Contact us	12/24/2015	09/24/2015	0%	11/19/2015	0%	11/26/2015	0%	12/10/2015	12/20/2015	Enterprise CRQs (5 days) + DBA tasks				
	Release 3 - Go-Live (Membership Effective) - (02/01/2014)														
	Care Management														
Not Started	Dynamo (R1)	12/24/2015	10/01/2015	0%	11/19/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	Dynamo Remote/Disconnected	12/24/2015	10/01/2015	0%	11/19/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	Dynamo (Web Portal)	12/24/2015	10/01/2015	0%	11/19/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	Enterprise CRQs (5 days) + DBA tasks				
	Claims & Payment														
Not Started	EDI Claim Import (File Load)	12/24/2015	10/08/2015	0%	11/12/2015	0%	11/23/2015	0%	11/30/2015	12/20/2015	DRM process (2 weeks) + DBA tasks				
Not Started	EDI Claim Import (Post Import + COB Loading)	12/24/2015	10/08/2015	0%	11/12/2015	0%	11/23/2015	0%	11/30/2015	12/20/2015	DRM process (2 weeks) + DBA tasks				
Not Started	EDI Claim Post MAS + COB Reporting	12/24/2015	10/08/2015	0%	11/12/2015	0%	11/23/2015	0%	11/30/2015	12/20/2015	DRM process (2 weeks) + DBA tasks				
Not Started	EDI Claim Lookup	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/26/2015	0%	12/10/2015	12/20/2015	Enterprise CRQs (5 days) + DBA tasks				
Not Started	QR Audit	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	iHealth interface (only HCFA)	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	Auxilliary Check Process (ACP)	12/24/2015	10/08/2015	0%	11/12/2015	0%	11/23/2015	0%	11/30/2015	12/20/2015	DRM process (2 weeks) + DBA tasks				
Not Started	Auxilliary Check Process (ACP) - Sampling EOB - Messaging to Members	12/24/2015	10/08/2015	0%	11/12/2015	0%	11/23/2015	0%	11/30/2015	12/20/2015	DRM process (2 weeks) + DBA tasks				
Not Started	Auxilliary Check Process (ACP) - Sampling EOB : Reporting	12/24/2015	10/08/2015	0%	11/12/2015	0%	11/23/2015	0%	11/30/2015	12/20/2015	DRM process (2 weeks) + DBA tasks				
Not Started	Emdeon (ABF) Checks	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	Provider Payment Set up (Import/Export)	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	EFT Web Forms (also covers ERA)	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
	Clinical & Utilization Management														
Not Started	Medicaid Web Portal	12/24/2015	09/24/2015	0%	11/19/2015	0%	11/26/2015	0%	12/10/2015	12/20/2015	Enterprise CRQs (5 days) + DBA tasks				
Not Started	CWQI (bulk data loader and auth grabber)	12/24/2015	09/24/2015	0%	11/19/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	NOA	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/26/2015	0%	12/10/2015	12/20/2015	Enterprise CRQs (5 days) + DBA tasks				
Not Started	ProPat	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/26/2015	0%	12/10/2015	12/20/2015	Enterprise CRQs (5 days) + DBA tasks				
Not Started	ProFax	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/26/2015	0%	12/10/2015	12/20/2015	Enterprise CRQs (5 days) + DBA tasks				
Not Started	ProReport	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	PPM (Predictive Pathways Model)	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	Grievances & Appeals - Config & Letters	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	Grievances & Appeals - Letters 2	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	Grievances & Appeals - Reports	12/24/2015	10/22/2015	0%	11/26/2015	0	11/30/2015	0	12/14/2015	12/20/2015	DBA tasks (24 hours)				
	Other Ancillary Files														
Not Started	CAQH (Quality)	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	Patriot Act	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	First Recovery Group (TPL)	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				

Duals Plan and IT Dashboard /Release 3

Iowa **Release 3**

`	Task Name	Business Need Date	Req End Date	Req % complete	Dev End Date	Dev % Complete	QA End Date	QA % complete	UAT End Date	Depl. Date	Deployment Req	Business Resources	Blocked Requirements/Dependencies	Status/Remarks	BA
Not Started	Claims history file (#12) (One time load)	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	Medicaid - Vendor Paid Claim Files (Plan Audit load) Vision	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	Medicaid - Vendor Paid Claim Files (Plan Audit load) Pharmacy	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	Medicaid - Vendor Paid Claim Files (Plan Audit load) Transportation	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	Medicaid - Vendor Paid Claim Files (Plan Audit load) Dental	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0	12/14/2015	12/20/2015	DBA tasks (24 hours)				
	Admin Simplification - Emdeon														
Not Started	270/271 - Admin Simplification	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	276/277 - Admin Simplification	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	278 - Admin Simplification	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/26/2015	0%	12/10/2015	12/20/2015	Enterprise CRQs (5 days) + DBA tasks				
	Med Solutions														
Not Started	Med Solutions (Radiology)	12/24/2015	10/01/2015	0%	11/19/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
	CSS Apps														
Not Started	ClaimCheck	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	AutoQ	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	Interest Penalty (EDI & Non EDI) - Base configuration tables	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	ADA Interest Penalty (Front end)	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/26/2015	0%	12/10/2015	12/20/2015	Enterprise CRQs (5 days) + DBA tasks				
Not Started	Microdyn	12/24/2015	10/22/2015	0%	11/26/2015	0	11/30/2015	0	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	3M APC Pricer	12/24/2015	10/22/2015	0%	11/26/2015	0	11/30/2015	0	12/14/2015	12/20/2015	DBA tasks (24 hours)				
Not Started	Auto Promote	12/24/2015	10/22/2015	0%	11/26/2015	0%	11/30/2015	0%	12/14/2015	12/20/2015	DBA tasks (24 hours)				

Duals Plan and IT Dashboard /Release 4

Iowa **Release 4 Encounters & Paid Claims**

Status	Task Name	Business Need Date	Req End Date	Req % Complete	Dev End Date	Dev % Complete	QA End Date	QA % complete	UAT End Date	Depl. Date	Deployment Req	Business Resources	Blocked Requirements	Status/Remarks	BA
	Release 4 - Encounters														
Not Started	Medicaid - 837I	02/01/2016	11/23/2015	0%	12/21/2015	0%	01/04/2016	0%	01/11/2016	01/31/2016	DRM process (2 weeks) + DBA tasks				
Not Started	Medicaid 837P - Version 1	02/01/2016	11/23/2015	0%	12/21/2015	0%	01/04/2016	0%	01/11/2016	01/31/2016	DRM process (2 weeks) + DBA tasks				
Not Started	Medicaid 837 Transportation	02/01/2016	11/23/2015	0%	12/21/2015	0%	01/04/2016	0%	01/11/2016	01/31/2016	DRM process (2 weeks) + DBA tasks				
Not Started	Medicaid 837 Dental	02/01/2016	11/23/2015	0%	12/21/2015	0%	01/04/2016	0%	01/11/2016	01/31/2016	DRM process (2 weeks) + DBA tasks				
Not Started	Medicaid 837 Vision	02/01/2016	11/23/2015	0%	12/21/2015	0%	01/04/2016	0%	01/11/2016	01/31/2016	DRM process (2 weeks) + DBA tasks				
Not Started	Pharmacy NCPDP D.O	02/01/2016	11/23/2015	0%	12/21/2015	0%	01/04/2016	0%	01/11/2016	01/31/2016	DRM process (2 weeks) + DBA tasks				
Not Started	Medicaid - Vendor Encounter Files (EMC_Vendor_data tables) Vision	02/01/2016	11/16/2015	0%	12/28/2015	0%	01/18/2016	0%	01/25/2016	01/31/2016	DBA tasks (24 hours)				
Not Started	Medicaid - Vendor Encounter Files (EMC_Vendor_data tables) Pharmacy	02/01/2016	11/16/2015	0%	12/28/2015	0%	01/18/2016	0%	01/25/2016	01/31/2016	DBA tasks (24 hours)				
Not Started	Medicaid - Vendor Encounter Files (EMC_Vendor_data tables) Transportation	02/01/2016	11/16/2015	0%	12/28/2015	0%	01/18/2016	0%	01/25/2016	01/31/2016	DBA tasks (24 hours)				
Not Started	Medicaid - Vendor Encounter Files (EMC_Vendor_data tables) Dental	02/01/2016	11/16/2015	0%	12/28/2015	0%	01/18/2016	0%	01/25/2016	01/31/2016	DBA tasks (24 hours)				
Not Started	835 Remittance Advice (TBD - plansubidYYYYMMDD5010.835)	02/01/2016	11/23/2015	0%	12/21/2015	0%	01/04/2016	0%	01/11/2016	01/31/2016	DBA tasks (24 hours)				

Duals Plan and IT Dashboard /Changes

Iowa **Changes**

Task Name	Business Need Date	Business Resources	Blocked Items	Status/Remarks	BA
Change Request					

Sample Incident Ticket

BMC REMEDY IT SERVICE MANAGEMENT
Incident
Welcome, ANIL K KEDIA
Help Logout
bmcsoftware

IT Home > INC000000051124

0 New Broadcast

Identification and Recording | Investigation and Diagnosis Normal | Resolution and Recovery | Incident Closure | Closed

Quick Action
- Assign to Me
- Auto Assign
- Broadcast Incident
- Create Relationship to
- Create Related Reque:
- Customer's Incidents
- Incident Matching
- Process Overview
- Select Operational
- Select Product

SLM Status
Details...
Links
Functions

Incident ID*+	INC000000051124
Company*+	Aetna
Customer*+	JONES, SHARON L
Contact+	
Notes	
Template+	IT MAS - DBA - Backdoor Update
Summary*	New Autopromote for DPCI 5.1 mig
Service*+	
CI+	
Target Date	
Impact*	4-Minor/Localized
Urgency*	4-Low
Priority*	Low
Incident Type*	User Service Restoration
Reported Source	Email

Work Detail | Relationships | Date/System | Additional Details

1 entries returned - 1 entries matched | Preferences | Refresh

Type	Summary	Files	Submit Date
General Information	New Autopromote for DPCI	1	7/11/2014 8:49:11 AM

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Appendix Q

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13.2 (Q1) Disaster Recovery Plan / Contingency and Continuity Plan

Business Continuity Management Program Overview
(Pages 942 – 947)

Incident Management Plan
(Pages 948 – 979)

Disaster Backup and Recovery (DBAR)
(Pages 980 – 982)

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Business Continuity Management

Program Overview

Updated: August 1, 2014

Background

In keeping with Aetna's commitment to provide the highest quality service to its customers, Aetna has a comprehensive Business Continuity Management (BCM) Program to manage business disruptions.

The mission and purpose of the BCM Program is to:

- Improve the resiliency of Aetna against any disruption of services;
- Ensure Aetna has the ability to deliver services to our customers during events that negatively impact operations;
- Provide a defined framework to identify critical operations, associated risks and impacts and develop appropriate recovery strategies; and
- Validate plan strategies and capabilities through testing and maintenance.

The BCM Program is responsible for:

- Determining the company's objectives and statutory duties based on the organization's operating environment with regards to business continuity;
- Identify activities, assets and resources, and their respective criticality to the business that may comprise business operations;
- Setting and documenting the business continuity responsibilities of the organization, based on Management directives;
- Maintaining the Business Continuity Policy, standards, and technical controls for the organization, including the review of policy and standards on a regular basis;
- Determining and supporting proper methodologies and processes for business continuity;
- Communicating business continuity responsibilities including a formal training and awareness program in accordance with the applicable program requirements and maintaining the records;
- Maintain the Business Continuity Management (BCM) program including regular program reviews, updates to documentation and associated procedures;
- Implementing a program to exercise and test business continuity procedures and crisis management plans on a regular basis;
- Implementing performance objectives depending up on the results of the hazard identification, risk assessment, and business impact analysis to address both short-term and long-term needs defined by the organization.

BCM Program Framework

Aetna's BCM Framework aligns with industry standards and provides a consistent methodology across the enterprise to manage program elements. They are:

BCM Program Framework

- ✓ *Program Management*
- ✓ *Risk Assessment*
- ✓ *Business Impact Analysis*
- ✓ *Strategy Development*
- ✓ *Business Continuity Plan*
- ✓ *Incident Management Plan*
- ✓ *Training & Awareness*
- ✓ *Exercise & Maintenance*
- ✓ *Vendor Continuity*

BCM Plan Requirements

BC Plans are developed and documented within each business area with business processes identified as critical based on their availability requirements', impact and operational complexity.

Plans focus on:

- Identification and documentation of all pertinent information relative to business operations:
  - Critical business processes / functions and associated Maximum Allowable Downtime (MAD), Recovery Time /Point Objectives;
  - Recovery priorities for business functions, systems, and support services: prioritization of business functions;
  - Staff and skilled support personnel who are required to recover and sustain business functions;
  - Vital data, files, manuals, forms and documentation;
  - Information technology: hardware and software;

- Voice and data communication requirements: these include, but may not be limited to, phones, faxes, modems, leased lines, LANs, VANs, WANs, and mainframe applications;
- Critical Vendors;
- Workspace requirements (e.g., number of work stations, furniture and special equipment).

BC Planning Assumptions

The BCM Program focuses continuity strategy and planning on the following scenarios:

1. Scenario One – "Systems OK, No Building"

- This scenario assumes partial or total loss of the building in which one or more critical operations are located. The planning strategies focus on short term and long tern outages where critical services are performed.

2. Scenario Two – "Building OK, No Systems"

- This scenario assumes loss of critical systems/applications affecting business dependent operations or the entire enterprise.

3. Scenario Three – "Third Party Business Disruption"

- This scenario assumes loss of a key third party services.

4. Scenario Four – "Severe Widespread Staffing Shortage"

- This scenario assumes staffing shortages as a result of a regional or global Pandemic, Bio-Terrorism or event that limits staff availability for an extended period of time.
- As part of Aetna's pandemic planning, the assumption focuses on loss of employees for a period of 6-8 weeks at a time, with 2-3 waves over an 18 month period.

5. Scenario Five – "Loss of Telework Capability"

- This situation assumes a loss of Telework members' capability due to an infrastructure disaster or a widespread natural disaster. It includes loss of: broadband internet, power, connectivity, telephony and individual worksites.

Plan Maintenance & Testing

Aetna's Business Continuity Management Program actively delivers exercises, testing and maintenance process requirements. Each plan conducts an annual tabletop exercise and validates plan content and team contacts quarterly. The plan reviews confirm all major plan components remain current.

BCP plans are tested during simulation exercises which are conducted on an ongoing basis with at least three delivered annually to field offices. The plans are also tested during actual events like severe wild fires, floods, hurricanes and other natural or man-caused disaster events.

For further information, please contact The Office of Business Continuity

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Attachment A: Incident Classification Scheme

IMPACT / RISK	Monitoring	Low (Level 3)	Moderate (Level 2)	Major (Level 1)
Operational:	Threat *(e.g., Weather: hurricane, winter storm)* Situation threatens Aetna employees, operations, assets, information and/or critical vendor(s)	• Loss of local IT Infrastructure • Limited operational impact to Aetna business	• Moderate operational impact	• Multiple sites / regional impact
Vendor:		• Critical Vendor outage with limited impact	• Vendor outage with moderate impact to Aetna business	• Critical operational vendor outage affecting multiple business lines
Employee Safety:		• No risk	• Moderate risk of injury	• Significant risk
Operations:		• Minimal impact	• Impacts multiple business segments	• Widespread impact to business segments
Site:		• Single site event • Low impact on operations • Tier 3 site	• Multiple site event • Single Tier 1 site with moderate impact to operations • Tier 2 site	• Multiple site event • Single Tier 1 site impact with extended outage and impact to operations
System / Telephony:		• Localized impact • < 24 hrs. or less outage duration	• Multi-business impact • >24 hr. outage duration • Tier 1 Systems	• Multiple Tier 1 Application or System outages • Significant infrastructure impact • Loss of data center
Vendor:		• Minimal impact on Aetna operations and low duration outage • Tier 3 Vendor	• Moderate impact on Aetna operation business areas with outage impact greater • Tier 2 Vendor	• High impact to Aetna operations • Outage greater than 5 days • Tier 1 Vendor

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Site Lead Acknowledgement Date:	5/29/2014

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DISASTER BACKUP AND RECOVERY (DBAR)

STRATEGIC OVERVIEW

Aetna's disaster backup and recovery (DBAR) strategy is to provide and maintain an internal disaster recovery capability. The strategy leverages Aetna's internal computer processing capacity of its two large state of the art and hardened computer data centers, located in both Middletown and Windsor, Connecticut. Both facilities have extensive fire suppression systems, dual incoming power feeds, UPS and backup diesel generators which provide 24x7x365 operations. Physical access is strictly controlled and monitored and access to vital areas is segregated by floor and business function where appropriate. The two data centers house Aetna's computer processing capabilities on 3 major platforms, mainframe (Z/OS), mid-range (Various UNIX versions), and LAN (Windows on X86 processors). The data centers are load-balanced and supplemented by quick ship and capacity on demand contracts so each location can back the other up in the event of a disaster. Contracts with national vendors are maintained to obtain replacement equipment and supplemental capacity as needed to ensure recovery time objectives (RTO) can be met.

In the event of a data center disaster, the RTO to resume most production processing is 4 days from disaster declaration for all mainframe and mid-range systems, 5 days for LAN systems. Portfolios of highly available applications, such as Web and Pharmacy, have RTO's of 6 hours or less. These applications utilize mirroring and/or load balancing and Active/Active technologies between the data centers to ensure that the reduced RTO's can be met. Aetna's voice and data network backbones are fully redundant using SONET ring and MPLS technology and are recovered within 1 hour of a data center outage. In summary, Aetna's data center recovery strategy and its application RTO's are consistent with or better than industry standards.

DATA BACKUP

Infrastructure and application data is secured and stored offsite on a daily basis. Backed-up data are cross vaulted between the two computer centers and is stored primarily on disk media. Data backup frequency in the midrange and LAN environments is a full backup weekly, with nightly incremental backups. The Database Administrators also backup each application database separately as an additional step in redundancy. Additionally, all mainframe disk and tape data is mirrored to the alternate data center providing a simplified and timelier recovery in that platform of the environment.
Any customer data lost as a result of a data center catastrophe will be recovered through resubmittals by service providers and/or recovery reconciliation teams.

DISASTER RECOVERY PLANS

Aetna's Integrated Infrastructure Services (IIS) Executive IT Disaster Recovery Plan (The Executive Plan) is the high level plan for recovery of a data center and its critical components. The plan is derived from over 50 detailed IT infrastructure plans which are maintained by each critical support area. The plans contain processes and procedures to recover all functions, services, and equipment which are needed to recover either data center. These plans are centrally maintained by our disaster recovery group, are stored both locally and offsite and are updated semi-annually or as needed by the respective infrastructure area.

Application recovery (DBAR) plans document technical and management contacts, application recovery specifics, application dependencies, integrated system synchronization, and check-out procedures. The plans are maintained routinely and utilize automated recovery processes to insure appropriate data resilience. These DBAR Plans are validated semi-annually with the application owners and business users with periodic integrated table-top simulations.

Escalation and notification procedures are contained within these Disaster Recovery plans to ensure recovery team members, affected partners and business unit owners are activated in a timely manner.

IIS's role during a disaster is to lead, manage, and staff the various recovery teams which will also be augmented by additional vendor specialists under contract for certain supplemental or vendor-contracted recovery technologies which IIS will coordinate.

DISASTER RECOVERY TESTING

Aetna maintains and implements ongoing enhancements to the disaster recovery plans and procedures. Testing is performed across a variety of applications and infrastructure components on a regular basis to ensure ongoing disaster recovery readiness. Aetna routinely tests recovery elements of third-party relationships including technology components, critical processes and access points. These exercises can be initiated by either party and Aetna welcomes the opportunity to test these relationships as time and resources permit.

BUSINESS CONTINUITY

Aetna maintains and implements a detailed business continuity program, with over 300 plans to address its critical business work group operations. In the event of an office outage processing is transferred to surviving offices within Aetna's network with little or no disruption to service levels. The detailed business continuity plans are maintained on a quarterly basis and in-depth tests are conducted periodically. Business Continuity Plans are also designed to mitigate the effects of an extended system outage and loss of third-party business associates, as well as address severe staffing shortages.

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Appendix R

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13.5.3 Encounter Implementation Plan

	Task Name	Duration
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	Task Name	Duration
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	Task Name	Duration
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Appendix X

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9.1.1 (Q1) Health Risk Screening Tool

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Health History

1. How tall are you?
   - Feet and Inches
2. How much do you weigh?
   - lbs
3. Do you have a health condition?
   - Yes
   - No
   - I Don't Know
4. Which of the following health conditions have you ever had?
   - Abnormal Uterine Bleeding
   - Acid reflux (GERD)
   - Adult Asthma
   - Aortic Aneurysm of the abdomen (AAA)
   - Arthritis (Osteoarthritis, wear and tear of joints)
   - Arthritis (Rheumatoid)
   - Atrial Fibrillation (Chronic)
   - Bipolar Disorder (manic-depression)
   - Breast Cancer
   - Cervical Cancer
   - Chronic Back or Neck Pain (>3 months)
   - Colon Cancer
   - Congestive Heart Failure (a weak heart)
   - COPD (Chronic Bronchitis or Emphysema)
   - Coronary Heart Disease (a blockage of the blood vessels of your heart)
   - Crohn's Disease or Ulcerative Colitis
   - Cystic Fibrosis
   - Depression
   - Diabetes (Type 1 or 2)
   - Hepatitis from a virus (Hepatitis A, B, or C)
   - High Blood Pressure
   - High Cholesterol
   - Hypercoagulable State (tendency to form blood clots)
   - Irritable Bowel Syndrome (IBS)
   - Kidney Disease (chronic, CKD)
   - Leukemia or Lymphoma
   - Lung Cancer
   - Lupus (SLE)
   - Melanoma
   - Migraines
   - Obesity (Body Mass Index of 30 or more)
   - Osteopenia (borderline osteoporosis)
   - Osteoporosis (significant bone loss)
   - Ovarian Cancer
   - Parkinson's Disease
   - Peripheral Artery Disease (poor circulation)
   - Pre-diabetes
   - Prostate Cancer

- Seizures
- Sickle Cell Disease
- Skin Cancer – other
- Sleep Apnea (Obstructive Sleep Apnea)
- Spina Bifida
- Stomach Ulcers (Peptic Ulcer Disease)
- Stroke (CVA or TIA - mini stroke)
- Thyroid Disease - high or overactive thyroid (Hyperthyroid)
- Thyroid Disease - low or underactive thyroid (Hypothyroid)
- Uterine Cancer (endometrial cancer)

5. Which of these best describes you?
   - I am in menopause or post-menopausal
   - I plan to get pregnant soon
   - I am currently not pregnant
   - I am pregnant
   - I have never given birth and I am unable to have children
   - I am not able to get pregnant
   - I gave birth recently (in the last 6 months)
   - None of the above
6. How's your health?
   - Excellent
   - Very Good
   - Good
   - Fair
   - Poor
7. What was your blood sugar level the last time you checked it?
   - Glucose Level
8. Were you fasting at the time of the blood test?
   - Yes
   - No
   - I Don’t Know
9. Have you checked your hemoglobin-A1c level in the last 6 months?
   - Yes
   - No
   - I Don’t Know
10. What was the result of your A1C test?
    - A1c level
11. What is your most recent blood pressure?
    - Systolic
    - Diastolic
    - I don’t know one or both
12. Has your cholesterol been checked in the past year?
    - Yes
    - No
    - I Don’t Know
13. Has your cholesterol been checked in the past 6 years?
    - Yes
    - No
    - I Don’t Know
14. If you know the results of your most recent cholesterol test, please enter the values below.

- Total Cholesterol
- LDL (Bad) Cholesterol
- HDL (Good) Cholesterol
- Triglycerides
- I Don’t Know

15. Do you have any visual impairments (troubleseeing)?
    - Minimal - can read headlines or large print
    - Moderate - Cannot read at all but can see obstacles in the way
    - Severe - Cannot see obstacles, only light from dark
    - Total impairment
    - No impairment
16. When was your last eye exam by an eye doctor?
    - In the last 12 months
    - In the last 2 years
    - In the last 3 years
    - In the last 4 years
    - More than 4 years ago
    - I don't remember
    - I have never had an eye exam by an eye doctor
17. Do you have any hearing impairment?
    - No impairment
    - Moderate - can hear if spoken to in loud, slow voice
    - Total - no hearing at all
18. Have you had a mammogram in the past year?
    - Yes
    - No
    - I Don’t Know
19. Have you had a Pap smear in the past 3 years?
    - Yes
    - No, my provider told me I do not need this test
    - I Don’t Know
20. Which of the following colon cancer tests have you had?
    - Stool blood testing kit in the past 12 months
    - Sigmoidoscopy, Virtual Colonoscopy, or contrast enema in the last 5 years
    - Colonoscopy in the last 10 years
    - None of these
    - I don't know
21. Do you get a flu shot each year?
    - Yes
    - No
    - No, but I am allergic or was told by my provider not to get this vaccine
    - I Don’t Know
22. A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?
    - Yes
    - No
23. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed it?
    - Never
    - Sometimes
    - Usually

- Always

24. Did you visit your dentist in the past year?
- Yes
- No
- I don’t remember

25. Did you visit your dentist in the past 6 months?
    Yes
    No

Lifestyle

26. How's your stress level?
    - High
    - Moderate
    - Low
27. Are you a current tobacco user?
    - Yes
    - No
28. Which of these tobacco products have you ever used?
    - Cigarettes
    - Cigars
    - Pipe
    - Chewing tobacco
    - Snuff
    - I have not used tobacco
29. Which ones did you use in the last 4 weeks?
    - Cigarettes
    - Cigars
    - Pipe
    - Chewing tobacco
    - Snuff
    - I have not used tobacco in the last 4 weeks
30. Do you drink beer, wine or other alcoholic beverages?
    - Yes
    - No
31. Have you had 15 or more alcoholic drinks in a week in the past 3 months?
    - Yes
    - No
32. Have you had 8 or more alcoholic drinks in a week in the past 3 months?
    - Yes
    - No
33. Do you do any aerobic or "cardio" physical activity?
    - I am inactive (besides activities of daily living)
    - I do moderate aerobic activity (brisk walking, biking on flat roads, or have an active job)
    - I do intense aerobic activity (e.g., jogging, biking uphill, moving furniture)
    - I do BOTH moderate and intense activities
    - My health care provider told me not to do this kind of physical activity
34. How many hours a week do you have an intense workout?

- Less than 1 hour
- Between 1 - 1.25 hours
- Between 1.25 - 2.5 hours
- More than 2.5 hours

35. How many hours a week do you do moderate activities?
    - Less than 2.5 hours
    - Between 2.5 - 5 hours
    - More than 5 hours
    - Other (enter number of hours per week)
36. How many days a week do you lift weights or do resistance exercises?
    - My health care provider told me not to do this type of physical activity
    - I don't do these activities
    - 1 day a week
    - 2 or more days a week
    - Other (enter days per week)
37. How often do you wear your seatbelt?
    - All of the time (front and back seats)
    - All of the time but in the front seats only
    - Sometimes
    - Never
    - I don't travel in a car
38. How many hours of sleep do you usually get each day?
    - More than 9 hours
    - Less than 7 hours
    - Between 7 and 9 hours
39. Which of these best describes your eating habits?
    - I eat a vegetarian diet
    - I don't eat `red' meat at all
    - I eat 5 or more servings of fruits and vegetables regularly
    - I limit my intake of fatty foods and trans fats
    - I limit my salt intake
    - I limit my intake of sweetened drinks and sugary foods
    - I follow a diet prescribed by my health care providers
    - I don't follow any of these diets or dietary habits

Improving Your Health

40. In the past year, how many days did you miss work because you were sick?
    - 5 days or less
    - More than 5 days
    - I am not working now, or I am retired
41. How satisfied are you with your life in general?
    - Very satisfied
    - Partly satisfied
    - Not satisfied
42. Have you felt little interest or pleasure in doing things in the past 2 weeks?
    - Yes
    - No
43. Have you felt down, depressed, or hopeless in the past 2 weeks?
    - Yes
    - No

44. In the last month, how often did your pain keep you from going to work, doing housework, enjoying an evening out or other activities?
    - Number of days
    - None
45. Which health goal is most important to you?
    - Cutting down or quitting tobacco use
    - Decreasing the amount of alcohol that you drink
    - Eating a healthier diet
    - Increasing your level of physical activity
    - Increasing the amount of weight-bearing exercises you do
    - Losing weight
    - Managing stress better
    - No preference
46. How confident are you of reaching at least one of your health goals?
    - Extremely confident
    - Very confident
    - Rather confident
    - Somewhat confident
    - Not confident
47. Which of the following stops you from trying to improve your health?
    - No time
    - Fear of failing
    - No desire and energy
    - Giving up things I enjoy
    - Bother to my family and/or friends
    - Not sure what I need to do or how to get help
    - None of these

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Tab 6: RFP Forms, Financial Statements, Resumes, Contract Lists, and Selected Attachments

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RFP FORMS, FINANCIAL STATEMENTS, RESUMES, AND CONTRACT LISTS

The following items should be included in Tab 6 and will not count toward the 1000 page limit:

3.2.7.1 RFP Forms

The forms listed below are exhibits to this RFP. Fully complete and return these forms behind Tab 6:

- **Release of Information Form**
- **Primary Bidder Detail & Certification Form**
- **Subcontractor Disclosure Form (one for each proposed subcontractor)**

Aetna Better Health of Iowa, Inc. (Aetna Better Health) understands and will comply. Please find the following forms behind Tab 6: Exhibit A: Release of Information Form and Tab 6: Exhibit B: Primary Bidder Detail and Certification Form Release of Information Form

- Release of Information Form
- Primary Bidder Detail & Certification Form

Please note that Subcontractor Disclosure Forms (one for each proposed subcontractor) were omitted from Proposal submission requirements as part of the Second Round of Questions and Answers with the Agency during the procurement process. These forms are now required for submission upon Contract execution.

3.2.7.2 Financial Statements

The bidder shall submit audited financial statements from independent auditors for the last three (3) years. for the bidder and the ultimate controlling parent of the bidder, if any. Entities not required to have audited financial statements may submit CPA-prepared unaudited financial statements. Please submit your NAIC number in Exhibit B. While considered a part of Tab 6, copies of financial statements should be bound and labeled separately from the rest of the proposals. Please see the table Section 3.1 for further instructions on how to submit financial statements.

Aetna Better Health understands and will comply. Please find the requested Audited Financial Statements located in the Financial Statements binder as Appendix A.

3.2.7.3 Resumes

Put staff resumes referenced in RFP Section 3.2.5.2.3 here.

Resumes for Aetna Better Health of Iowa, Inc.'s Key Personnel are included for your review behind the tab titled "3.2.7.3 Resumes" in the (Tab 6) binder.

3.2.7.4 Contract Lists

3.2.7.4.1 Reserved.

3.2.7.4.2 Table, Question 1

1. **Identify in table format all of your publicly-funded managed care contracts for Medicaid, CHIP and other low-income populations within the last five (5) years. If a Bidder does not have direct experience, it may include the experience of its parent company if it includes a parent guarantee with its proposal. For each prior experience identified, provide a brief description of the following:**
   a. **Scope of work and covered benefits (state whether physical health, behavioral health, and long-term services and supports (LTSS) were in or out of scope);**
   b. **Duration of the contract;**
   c. **Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s);**
   d. **Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s);**
   e. **Contact name, phone number, and e-mail address;**
   f. **Number of members served by population type;**
   g. **Annual contract payments and description if payment was capitated;**
   h. **Any improvements made in utilization trends and quality indicators;**
   i. **How the contract emphasizes member choice, access, safety, independence, and responsibility; and**

j. **The role of subcontractors, if any.**

Aetna Better Health of Iowa, Inc. is not yet operational and therefore has no direct experience.

We have included publicly-funded managed care contracts for Medicaid, CHIP and other low-income populations within the last five (5) years for Aetna Medicaid Administrators, LLC (Aetna Medicaid) in Table T6-1 “Publicly-Funded Managed Care Contracts for Medicaid, CHIP and other low-income individuals” on the following pages. While the portion of the table listing contracts where an Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency cites the experience of our affiliates, as opposed to our parent, in the abundance of caution please find our parent guarantee for review behind Tab 1 as Appendix Y.

Table T6-1: Publicly-Funded Managed Care Contracts for Medicaid, CHIP and other low-income individuals

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Connecticut (Aetna Better Health of Connecticut)

a) Scope of work and covered benefits	Full scope of Medicaid and CHIP managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	3 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: July 2008 Contract ended: December 31, 2011 State of Connecticut terminated the managed care program.
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	State of Connecticut Department of Social Services Astread Farron-Poole 860-424-5510 Astread.Ferron-Poole@ct.gov
f) Number of members served by population type	**TANF:** 2011: 96,509 **CHIP:** 2011: 4,925 **Uninsured Adults:** 2011: 4,178
g) Annual contract payments and description if payment was capitated	**Capitated** 2011 - $24,434,097 2010 - $229,790,932
h) Improvements made in utilization trends and quality indicators	From FY 2010-FY 2011, utilization/1,000 decreased 7% for an inpatient facility setting along with a reduction in PMPM by 5.1%.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with the State of Connecticut Department of Social Services emphasized member choice, access, safety, independence and responsibility in the following ways: supported appropriate utilization of home health and home-based services, required care management for members residing in an inpatient facility or institutional setting along with provided members a broad network to access care.
j) Role of Subcontractor	Vision, translation services, and transportation

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Delaware (Delaware Physicians Care)

a) Scope of work and covered benefits	Full scope of Medicaid managed care services for acute, LTSS, and behavioral health services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	10 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: July 2004 The contract expired on its own terms on 12/31/2014.
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name, phone number and e-mail address	Delaware Health and Social Services Division of Medicaid & Medical Assistance Glyne Williams 302-255-9500 glyne.williams@state.de.us
f) Number of members served by population type	**TANF:** 2014: 118,098 **CHIP:** 2014: 7,691 **ABD**: 2014: 8,990 **LTSS:** 2014: 3,489 Dual Eligible: 2014: 3,601
g) Annual contract payments and description if payment was capitated	**Capitated** 2014 - $703,568,114 2013 - $753,627,338 2012 - $654,140,128 2011 - $491,991,856 2010 - $428,859,416
h) Improvements made in utilization trends and quality indicators	From 2012-2013, we successfully improved the HCBS ratio by approximately 7% over two years, resulting in a $13million savings. Additionally, from Sept. 2013- Sept. 2014, emergency department utilization/1,000 decreased 2.4%.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with Delaware Health and Social Services emphasized member choice, access, safety, independence and responsibility in the following ways: supported appropriate utilization of home health and home-based services, required care management for members residing in an inpatient facility or institutional setting along with provided members a broad network to access care. During the course of our 10 years with the State of Delaware, we began managing care for the LTSS population. As noted above, we were able to move significantly numbers of individuals residing in an institution to a home or community-based setting.
j) Role of Subcontractor	PBM, transportation, translation services, vision, printing, TPL and subrogation, radiology management, automated communications, payment remittance and fulfillment

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Florida (Coventry Health Care of Florida)

a) Scope of work and covered benefits	Full scope of Medicaid managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	7 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: September 11, 2007
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	Agency for Health Care Administration Kenyatta Smith 850-412-4068 Kenyatta.Smith@ahca.myflorida.com
f) Number of members served by population type	**TANF:** 2014: 35,699 2013: 48,737 2012: 43,757 2011: 37,969 2010: 38,205 **ABD and SSI:** 2014: 6,730 2013: 6,478 2012: 5,497 2011: 5,181 2010: 5,149
g) Annual contract payments and description if payment was capitated	**Capitated** 2014 - $106,157,243 2013 - $133,602,274 2012 - $112,493,754 2011 - $100,658,913 2010 - $111,678,701
h) Improvements made in utilization trends and quality indicators	From FY 2013-FY 2014, emergency department utilization/1,000 decreased by 10.7% for SSI and decreased 2.8% for the TANF population.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with AHCA emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members and care management programs targeting specific conditions such as diabetes and asthma. Additionally, the contract supports appropriate utilization of home health and home-based services and requires a broad network to access care.
j) Role of Subcontractor	Pharmacy benefits management, behavioral health and vision

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Florida (Coventry Health Care of Florida)

a) Scope of work and covered benefits	Full scope of CHIP managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	7 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: September 11, 2007
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	Florida Healthy Kids Corporation Paula Kiger 850-701-6102 kigerp@healthykids.org
f) Number of members served by population type	**CHIP:** 2014: 15,650 2013: 19,648 2012: 20,513 2011: 23,568 2010: 25,662
g) Annual contract payments and description if payment was capitated	**Capitated** 2014 - $24,421,065 2013 - $31,849,980 2012 - $35,234,230 2011 - $37,530,762 2010 - $38,977,286
h) Improvements made in utilization trends and quality indicators	From 2012-2014, HEDIS measures for Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life and Adolescent Well-Care Visits (awc) have consistently held steady at the 75th percentile. Additionally for the same measurement year, inpatient utilization has ranged from 4.38-4.93 discharges per 1,000, which is significantly below the national average of 8.88.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with Florida Healthy Kids emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members and care management programs targeting specific conditions such as diabetes and asthma. Additionally, the contract supports appropriate utilization of home health and home-based services and requires a broad network to access care.
j) Role of Subcontractor	Pharmacy benefits management, behavioral health and vision

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Florida (Coventry Health Care of Florida)

a) Scope of work and covered benefits	Full scope of managed care services for LTSS members who live in rural areas, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	1 year, 9 months
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: August 1, 2013 Contract End Date: May 1, 2014
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	Florida Statewide Medicaid Managed Care Angela Jones 850-412-4236 Angela.Jones@ahca.myflorida.com
f) Number of members served by population type	**LTSS:** 2014: 4,572 2013: 3,426
g) Annual contract payments and description if payment was capitated	**Capitated** 2014 - $142,751,231 2013 - $34,625,479
h) Improvements made in utilization trends and quality indicators	Care management for LTSS is currently managed by ILS. From April 1, 204 through March 31, 2015 Coventry Health Care of Florida has transitioned 116 members from nursing facilities to a home and community based setting, allowing those members to live at home or in a home like environment (ALF). Over the past year (April 1, 2014 through March 31, 2015) Coventry has provided home and community based services to 3,471 members, enabling those members to remain in their home or a home-like setting and avoid the increased costs associated with nursing facility placement.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with Florida Medicaid Managed Care emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, utilization of personal care services, private duty nursing and respite care. Additionally, the contract supports appropriate utilization of home health care services and requires a broad network for members to access care.
j) Role of Subcontractor	Vision, transportation, nurse line, language line, Electronic Visit Verification (EVV), and participant-directed option

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Florida (Coventry Health Care of Florida)

a) Scope of work and covered benefits	Administered the Long-Term Care Community Diversion Pilot Project program. Full scope of managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services with special emphasis on LTSS and HCBS services.
b) Duration of the contract	7 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original contract start date: September 11, 2007 Contract end date: February 28, 2014 The State phased out the Nursing Home Diversion program on February 28, 2014.
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	Nursing Home Diversion Program Florida Department of Elder Affairs Kristin Snyder 850-414-2361 Snyderk@elderaffairs.org
f) Number of members served by population type	**LTC/HCBS:** 2013: 0 2012: 1,165 2011: 1,061 2010: 1,319
g) Annual contract payments and description if payment was capitated	**Capitated** 2013 - $15,638,910 2012 - $19,642,985 2011 - $21,439,602 2010 - $25,392,538
h) Improvements made in utilization trends and quality indicators	From April 1, 204 through March 31, 2015 Coventry Health Care of Florida has transitioned 116 members from nursing facilities to a home and community based setting, allowing those members to live at home or in a home like environment. Over the past year (April 1, 2014 through March 31, 2015) Coventry has provided home and community based services to 3,471 members, enabling those members to remain in their home or a home-like setting and avoid the increased costs associated with nursing facility placement.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with Florida Department of Elder Affairs emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, utilization of personal care services, private duty nursing and respite care. Additionally, the contract supports appropriate utilization of home health care services and requires a broad network for members to access care.
j) Role of Subcontractor	Behavioral health, language line, dental, home health and vision

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Iowa (Coventry Health Care of Iowa)

a) Scope of work and covered benefits	Full scope of services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Benefits include physical and behavioral health services covered by program.
b) Duration of the contract	1.5 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: January 1, 2014
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract is periodically altered when the State adjusts our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	Department of Health Services Julie Lovelady 515-256-4644 jlovelady@dhs.state.ia.us
f) Number of members served by population type	**Medicaid Expansion** (101-138% FPL): 10,000
g) Annual contract payments and description if payment was capitated	**Capitated** 2014 - $42,100,000
h) Improvements made in utilization trends and quality indicators	New contract, utilization data year over year is not available yet.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with the Department of Health Services emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members and care management programs targeting specific conditions such as diabetes. Additionally, the contract supports appropriate utilization of home health and home-based services and requires a broad network to access care.
j) Role of Subcontractor	Behavioral health, pharmacy, vision, radiology and pain management

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Illinois (Aetna Better Health of Illinois)

a) Scope of work and covered benefits	Full scope of managed care services for ABD, LTSS and Seniors and Persons with Disabilities, including operations and ancillary support functions (legal, actuarial, and financial management)
b) Duration of the contract	4 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: May 2011
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	Illinois Department of Healthcare and Family Services Michelle Maher 217-524-7478 Michelle.Maher@Illinois.gov
f) Number of members served by population type	**ABD:** 2014: 25,346 2013: 15,376 2012: 18,086 2011: 6,904 **LTSS:** 2014: 5,333 2013: 2,769 2012: 0 2011: 0
g) Annual contract payments and description if payment was capitated	**Capitated** 2014 - $415,698,108 2013 - $305,211,544 2012 - $230,516,689 2011 - $86,040,866
h) Improvements made in utilization trends and quality indicators	From FY 2013-FY 2014, Inpatient Facility utilization/1,000 decreased 8.74% along with a reduction in PMPM by 8.89% for the ABD population. For the same measurement year, the LTSS population showed a reduction in inpatient facility utilization/1,000 by 44.68% along with a reduction in PMPM by 23%.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with Illinois Department of HealthCare and Family Services emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, utilization of personal care services, private duty nursing and respite care. Additionally, the contract supports appropriate utilization of home health care services and requires a broad network for members to access care.
j) Role of Subcontractor	Pharmacy benefits management, dental, vision, and transportation

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Illinois (Aetna Better Health of Illinois)

a) Scope of work and covered benefits	Full scope of managed care services for Medicare-Medicaid Alignment Initiative members includes medical management, operations and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	1 year followed by subsequent contracts that are now in place.
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: November 2013 Implementation: November 2014
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	Illinois Department of Healthcare and Family Services Michelle Maher 217-524-7478 Michelle.Maher@Illinois.gov Bureau of Managed Care
f) Number of members served by population type	**TANF:** 2014: 13,487 Duals: 2014: 7,467
g) Annual contract payments and description if payment was capitated	**Capitated** $119,900,000* *Based on projected membership growth
h) Improvements made in utilization trends and quality indicators	New contract started in 2014; utilization data is not available at this time.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with Illinois Department of Healthcare and Family Services emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, care management programs targeting specific conditions such as diabetes, utilization of personal care services, private duty nursing and respite care. Additionally, the contract supports appropriate utilization of home health care services and requires a broad network for members to access care.
j) Role of Subcontractor	Dental, vision, and transportation

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Kansas (Coventry Health Care of Kansas)

a) Scope of work and covered benefits	Full scope of managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	1 year
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: 2012 Contract ended: December 2012 The contract expired by its own terms on December 31, 2012, and was not renewed.
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments.
e) Contact name , phone number and e-mail address	Kansas Department of Health and Environment/Division of Health Care Finance Sharon Johnson 785-291-3657 SJohnson@kdheks.gov
f) Number of members served by population type	**TANF:** 2012: 121,524 **CHIP:** 2012: 29,691
g) Annual contract payments and description if payment was capitated	**Capitated** 2012 - $314,891,098
h) Improvements made in utilization trends and quality indicators	Contract only lasted 1 year; therefore year over year comparative utilization data is not available.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with the Kansas Department of Health and Environment/Division of Health Care Finance emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members and care management programs targeting specific conditions such as diabetes. Additionally, the contract supports appropriate utilization of home health and home-based services and requires a broad network to access care.
j) Role of Subcontractor	Transportation, pharmacy, dental, and behavioral health

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Kentucky (CoventryCares of Kentucky)

a) Scope of work and covered benefits	Full scope of managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	3 years and amended to present.
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Regions 1,2,4,5,6,7 and 8 Original Contract Start Date: November 2011; Contract signed July 2011 Region 3 Contract Start Date: January 2013 Contract signed in Oct. 2012
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	Lisa Lee Commonwealth of Kentucky (502) 564-4321 Lisa.Lee@ky.gov
f) Number of members served by population type	**TANF:** 2014: 167,971 2013: 160,395 2012: 121,673 2011: 117,724 **CHIP:** 2014: 10,046 2013: 23,413 2012: 18,565 2011: 18,000 Expansion: 2014: 68,845 **Duals:** 2014: 24,248
g) Annual contract payments and description if payment was capitated	**Capitated** 2014 - $1,437,979,389 2013 - $965,565,740 2012 - $867,505,794 2011 - $60,674,838
h) Improvements made in utilization trends and quality indicators	From FY 2013-FY 2014, inpatient facility utilization/1,000 decreased 19.3% for the children in foster care and a 2.9% reduction for the dual eligible population.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with Kentucky Medicaid Managed Care emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, care management programs targeting specific conditions such as diabetes and utilization of respite care. Additionally, the contract supports appropriate utilization of home health care services and requires a broad network for members to access care.
j) Role of Subcontractor	Pharmacy benefits management, behavioral health, dental, chiropractic, nurse line, and vision

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Michigan (CoventryCares of Michigan)

a) Scope of work and covered benefits	Full scope of Medicaid managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	10 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: October 1, 2004
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	Michigan Department of Community Health Plan Management Section Elizabeth Piper 517-335-5289 pipere@michigan.gov
f) Number of members served by population type	**TANF:** 2014: 26,775 2013: 29,471 2012: 33,235 2011: 37,043 2010: 41,496 **ABD/SSI:** 2014: 8,808 2013: 8,135 2012: 8,296 2011: 8,782 2010: 9,199
g) Annual contract payments and description if payment was capitated	**Capitated** 2014 - $108,041,925 2013 - $162,793,845 2012 - $172,512,939 2011 - $184,748,822 2010 - $187,640,450
h) Improvements made in utilization trends and quality indicators	From FY 2013-FY 2014, inpatient facility utilization/1,000 decreased 2% along with a reduction in PMPM by 2.1% for the SSI population. For the same measurement year, the plan showed a reduction in emergency department utilization/1,000 by 21.1% for the CHIP population.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with the Michigan Department of Community Health Plan emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, care management programs targeting specific conditions such as diabetes, CHF, and COPD. Additionally, the contract supports appropriate utilization of home health care services and requires a broad network for members to access care.
j) Role of Subcontractor	Pharmacy benefits management, behavioral health, dental (enhanced benefit for adult dental), transportation, lab, and nurse line.

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Michigan (CoventryCares of Michigan)

a) Scope of work and covered benefits	Full scope of CHIP managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	4 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: October 1, 2010
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	Michigan Department of Community Health Plan Management Section Elizabeth Piper 517-335-5289 pipere@michigan.gov
f) Number of members served by population type	**CHIP:** 2014: 1,795 2013: 1,423 2012: 619 2011: 492 2010: 177
g) Annual contract payments and description if payment was capitated	**Capitated** 2014 - $2,023,092 2013 - $836,107 2012 - $546,095 2011 - $364,158 2010 - The contract started in late 2010; there was no reported revenue until 2011.
h) Improvements made in utilization trends and quality indicators	From FY 2013-FY 2014, inpatient facility utilization/1,000 decreased 2.4% along with a reduction in PMPM by 2.1%. For the same measurement year, the plan showed a reduction in emergency department utilization/1,000 by 2%.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with the Michigan Department of Community Health Plan emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, care management programs targeting specific conditions such as diabetes, and asthma. Additionally, the contract supports appropriate utilization of home health care services and requires a broad network for members to access care.
j) Role of Subcontractor	Pharmacy benefits management, behavioral health, dental, transportation, vision, lab and nurse line

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Maryland (Coventry Health Care of Maryland)

a) Scope of work and covered benefits	Full scope of Medicaid managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	10 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: September 2003 Contract was voluntarily terminated on October 1, 2013, after Coventry acquisition, in order to continue operating Maryland Physicians Care Plan (detailed in the corresponding table showing contracts where Aetna is a subcontractor).
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	Maryland Department of Health and Mental Hygiene Susan Tucker 410-767-1432 susan.tucker@maryland.gov
f) Number of members served by population type	**TANF:** 2014: 0 2013: 0 2012: 11,734 2011: 14,425 2010: 12,372 **ABD:** 2014: 0 2013: 0 2012: 1,120 2011: 16,967 2010: 15,797
g) Annual contract payments and description if payment was capitated	**Capitated** 2014 - $66,911 2013 - $44,528,016 2012 - $54,959,958 2011 - $57,697,580 2010 - $46,420,355
h) Improvements made in utilization trends and quality indicators	From FY 2013-FY 2014, inpatient facility utilization/1,000 decreased 16.6% along with a reduction in PMPM by 17.5%. For the same measurement year, the plan showed a reduction in emergency department utilization/1,000 by 12.5%.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with the Maryland Department of Health and Mental Hygiene emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, care management programs targeting specific conditions such as diabetes, CHF, and COPD. Additionally, the contract supports appropriate utilization of home health care services and requires a broad network for members to access care.
j) Role of Subcontractor	Pharmacy benefits management, adult dental, substance use disorders, high-tech radiology, vision, and nurse line

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Maine (Schaller Anderson of Maine)	
a) Scope of work and covered benefits	Administered a care management program for MaineCare members who were high-cost, super utilizers. Did not provide benefits.
b) Duration of the contract	5 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: August 2006 Contract ended in April 2011 due to State budget cuts.
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	Fixed fee based on member acuity that was not known at the time as well as voluntary enrollment so initial value at contract execution was unknown. Actual compensation outlined in Row G below.
e) Contact name , phone number and e-mail address	MaineCare Care Management Benefit Stefanie Nadeau 207-287-2674 Stefanie.Nadeau@maine.gov
f) Number of members served by population type	**TANF:** 2014: 0 2013: 0 2012: 0 2011: 137,863 2010: 146,203 **CHIP:** 2014: 0 2013: 0 2012: 0 2011: 44,969 2010: 55,661 **ABD:** 2014: 0 2013: 0 2012: 0 2011: 20,305 2010: 34,418
g) Annual contract payments and description if payment was capitated	2011 - $1,854,933 2010 - $6,304,000 Fixed Fee
h) Improvements made in utilization trends and quality indicators	From Mar. 2010- Mar. 2011, inpatient facility utilization/1,000 decreased 22.2%, mental health inpatient utilization/1,000 decreased 14.7% and emergency department use decreased 4.2%.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with MaineCare Care Management Benefit emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members and integrated care management programs targeting specific conditions such as diabetes.
j) Role of Subcontractor	None

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Missouri (HealthCare USA)

a) Scope of work and covered benefits	Full scope of Medicaid and CHIP managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services. Pharmacy is carved-out.
b) Duration of the contract	20 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: 1995
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. . The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	MOHealthNet Susan Eggen 573-526-4274 Susan.m.eggen@dss.mo.gov
f) Number of members served by population type	**TANF:** 2014: 212,796 2013: 215,427 2012: 225,027 2011: 170,851 2010: 175,695 **CHIP:** 2014: 21,728 2013: 27,336 2012: 27,515 2011: 19,880 2010: 20,104
g) Annual contract payments and description if payment was capitated	**Capitated** 2014 - $600,189,238 2013 - $678,554,646 2012 - $668,310,056 2011 - $509,696,045 2010 - $512,030,812
h) Improvements made in utilization trends and quality indicators	From FY 2013-FY 2014, inpatient facility utilization/1,000 decreased 3.3% for the CHIP population. For the same measurement year, the plan showed a reduction in emergency department utilization/1,000 by 3.1% for the CHIP population along with 4.1% for the TANF population.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with the MOHealthNet emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, member incentive programs and care management programs targeting specific conditions such as diabetes and asthma. Additionally, the contract supports appropriate utilization of home health and home-based services and requires a broad network to access care.
j) Role of Subcontractor	Behavioral health, dental, transportation, vision, and nurse line

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Missouri (Missouri Care)

a) Scope of work and covered benefits	Full scope of Medicaid and CHIP managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services. Pharmacy is carved-out.
b) Duration of the contract	15 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: March 1998 Aetna Medicaid Contract ended March 2013* *In anticipation of Aetna's acquisition of Coventry and its Missouri health plan, the decision was made to divest former Aetna Medicaid health plan effective March 2013. We retained the Coventry plan, known as HealthCare USA, discussed in the section above.
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	MOHealthNet Susan Eggen 573-526-4274 Susan.m.eggen@dss.mo.gov
f) Number of members served by population type	**TANF:** 2014: 0 2013: 95,239 2012: 71,253 2011: 45,507 2010: 44,021 **CHIP:** 2014: 0 2013: 10,879 2012: 8,142 2011: 5,536 2010: 5,289
g) Annual contract payments and description if payment was capitated	**Capitated** 2013 - $75,049,913 2012 - $229,357,465 2011 - $138,432,568 2010 - $124,244,528
h) Improvements made in utilization trends and quality indicators	From Jan. 2012- Jan. 2013, inpatient facility utilization/1,000 decreased 3.6% along with a reduction in PMPM by 7.4% for the East region of Missouri. For the same measurement year and region, the data shows a reduction in mental health inpatient facility utilization/1,000 by 18%.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with the MOHealthNet emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, member incentive programs and care management programs targeting specific conditions such as diabetes and asthma. Additionally, the contract supports appropriate utilization of home health and home-based services and requires a broad network to access care.
) Role of Subcontractor	Transportation, vision, and dental

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Missouri (Missouri Care)

a) Scope of work and covered benefits	Administration of a care management program in North West Region of Missouri. Did not provide benefits.
b) Duration of the contract	1 year and 10 months
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Contract end date: July 2010 State terminated the contract due to budget cuts.
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the administrative rate was based on membership and periodically changed based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our administrative fee payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	MOHealthNet Susan Eggen 573-526-4274 susan.m.eggen@dss.mo.gov
f) Number of members served by population type	**TANF:** 2010: 31,021 **CHIP:** 2010: 3,617 **ABD:** 2010: 33,832
g) Annual contract payments and description if payment was capitated	Non-capitated; management fee only; monthly administrative fee $2,900,000
h) Improvements made in utilization trends and quality indicators	State terminated contract so utilization data is not available
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with the MOHealthNet emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, member incentive programs and care management programs targeting specific conditions such as diabetes, asthma, CHF and COPD. Additionally, the contract supports appropriate utilization of home health and home-based services and requires a broad network to access care.
j) Role of Subcontractor	None

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Nebraska (Aetna Better Health of Nebraska)

a) Scope of work and covered benefits	Full scope of Medicaid and CHIP managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	Service Area One, 4 years Service Area Two, 2 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: July 2010 Original Contract End Date: July 2012
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	Department of Health and Human Services, Division of Medicaid Dannie Elwood 402-471-2135 dannie.elwood@nebraska.gov
f) Number of members served by population type	**TANF:** 2014: 73,428 2013: 71,366 2012: 68,351 2011: 35,816 2010: 35,689 **CHIP:** 2014: 22,288 2013: 17,603 2012: 16,962 2011: 8,296 2010: 7,424 **ABD**: 2014: 7,885 2013: 7,859 2012: 7,549 2012: 0 2011: 3,929 2010: 3,711
g) Annual contract payments and description if payment was capitated	**Capitated** TANF, **ABD**, SSI, **CHIP:** 2014 - $236,792,964 2013 - $148,106,895 2012 - $172,276,495 2011 - $113,309,958 2010 - $42,423,851
h) Improvements made in utilization trends and quality indicators	From FY 2013-FY 2014, inpatient facility utilization/1,000 decreased 4.18% along with a reduction in PMPM by 4.22% for the ABD population. For the same measurement year, the CHIP population showed a reduction in inpatient facility utilization/1,000 by 20.76% along with a reduction in PMPM by 29.01%.
i) How the contract emphasizes member choice, access, safety,	The contract held with the Department of Health and Human Services emphasizes member choice, access, safety, independence and responsibility through health education and

Nebraska (Aetna Better Health of Nebraska)

independence, and responsibility	initiatives, care coordination to support continuity of care for all members, member incentive programs and care management programs targeting specific conditions such as diabetes, asthma, CHF and COPD. Additionally, the contract supports appropriate utilization of home health and home-based services and requires a broad network to access care.
j) Role of Subcontractor	Vision, dental, pharmacy benefits administration, behavioral health and transportation

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

New Hampshire (Schaller Anderson of New Hampshire)

a) Scope of work and covered benefits	Primary care case management (PCCM) and administrative services for Medicaid recipients. Did not provide benefits.
b) Duration of the contract	6 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original contract start date: July 1, 2007 Contract end date: June 30, 2013 State terminated PCCM contract when its new full risk Medicaid managed care program was implemented.
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the administrative rate was based on membership and periodically changed based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our administrative fee payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	New Hampshire Department of Health and Human Services Katie Dunn 603-271-9421 kdunn@dhhs.state.nh.us
f) Number of members served by population type	**TANF:** 2014: 0 2013: 113,780 2012: 114,518 2011: 104,937 2010: 1,231,049 **ABD**: 2014: 0 2013: 19,679 2012: 19,705 2011: 19,279 2010: 215,958
g) Annual contract payments and description if payment was capitated	Non-capitated; management fee only; monthly administrative fee 2013 - $782,578 2012 - $1,565,157 2011 - $1,565,158 2010 - $1,565,156
h) Improvements made in utilization trends and quality indicators	From Mar. 2010- Mar. 2011, mental health inpatient facility utilization/1,000 decreased 14.9% and emergency department utilization/1,000 decreased 6.1%.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with the New Hampshire Department of Health and Human Services emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members and care management programs targeting specific conditions such as diabetes, asthma, CHF and COPD.
j) Role of Subcontractor	None

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

New Jersey (Aetna Better Health of New Jersey)

a) Scope of work and covered benefits	Full scope of managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services, with special emphasis on LTSS and HCBS benefits.
b) Duration of the contract	6 months
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original contract start date: December 1, 2014. Contract is currently in effect.
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments.
e) Contact name , phone number and e-mail address	Department of Health Services Michelle Pawelczak (609) 588-3421 Michelle.Pawelczak@dhs.state.nj.us
f) Number of members served by population type	**LTSS:** 2015: 75 **TANF:** 2015: 6498 **ABD**: 2015: 1018
g) Annual contract payments and description if payment was capitated	**Capitated** New contract launched this year, no annualized payment information available
h) Improvements made in utilization trends and quality indicators	New contract launched this year; no utilization data available
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with the Department of Health Services emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, care management programs targeting specific conditions such as diabetes, utilization of personal care services, private duty nursing, options counseling and respite care. Additionally, the contract supports appropriate utilization of home health care services and requires a broad network for members to access care.
j) Role of Subcontractor	Dental, vision, behavioral health, language interpretation, Pharmacy Benefits Administration and Non-emergency Medical Transportation

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

New York (Aetna Better Health of New York)

a) Scope of work and covered benefits	Full scope of managed care services for LTSS members, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	2.5 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original contract start date: November 2012 Contract remains in effect.
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	New York State Department of Health Division of Long-Term Care Office of Health Insurance Programs Mark L. Kissinger 518-402-5673 mlk15@health.state.ny.us
f) Number of members served by population type	**LTSS:** 2014: 2,604 2013: 1,035 2012: 30
g) Annual contract payments and description if payment was capitated	**Capitated** 2014 - $113,093,309 2013 - $50,689,997 2012 - $117,737
h) Improvements made in utilization trends and quality indicators	From FY 2013-FY 2014, utilization/1,000 for home based services increased by 12% along with a reduction in institutional services by 29% for the LTSS population.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with the Department of Health Services emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, care management programs targeting specific conditions such as diabetes, utilization of personal care services, private duty nursing and respite care. Additionally, the contract supports appropriate utilization of home health care services and requires a broad network for members to access care.
j) Role of Subcontractor	Dental, vision, and transportation

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Ohio (Aetna Better Health of Ohio)

a) Scope of work and covered benefits	Full scope of managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services for dual eligibles.
b) Duration of the contract	5 months
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: June 1, 2014 Operations started January 1, 2015 Contract remains in effect.
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments.
e) Contact name , phone number and e-mail address	Department of Medicaid Laurel Smith 614-466-4443 Laurel.Smith@medicaid.ohio.gov
f) Number of members served by population type	Duals: 2015: 20,509 2014: 19, 634
g) Annual contract payments and description if payment was capitated	**Capitated** New contract, no annualized payment information is available.
h) Improvements made in utilization trends and quality indicators	New contract, no utilization data is available.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with the OH Department of Medicaid emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, utilization of personal care services, private duty nursing, coordination of Medicare benefits and respite care. Additionally, the contract supports appropriate utilization of home health care services and requires a broad network for members to access care.
j) Role of Subcontractor	Transportation, dental, vision, and pharmacy

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Pennsylvania (Aetna Better Health of Pennsylvania)

a) Scope of work and covered benefits	Full scope of managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	5 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: April 2010 Contract remains in effect.
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s)	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	Commonwealth of Pennsylvania Department of Public Welfare (DPW) of the Commonwealth of Pennsylvania Vivienne Elby-Bowers 717-772-6289 VELBYBOWER@state.pa.us
f) Number of members served by population type	**TANF:** 2014: 31,081 2013: 50,507 2012: 44,988 2011: 40,254 2010: 23,110 **ABD**: 2014: 15,567 2013: 13,672 2012: 10,623 2011: 7,890 2010: 3,629
g) Annual contract payments and description if payment was capitated	**Capitated** 2014 - $352,936,751 2013 - $321,062,237 2012 - $293,410,358 2011 - $251,329,744 2010 - $93,869,007
h) Improvements made in utilization trends and quality indicators	From FY 2013-FY 2014, inpatient facility utilization/1,000 decreased 19.85% along with a reduction in PMPM by 56.66% for the CHIP population.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with the Department of Public Welfare (DPW) emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members and integrated care management programs targeting specific conditions such as diabetes, asthma, COPD, and CHF. Additionally, the contract supports appropriate utilization of home health and home-based services and requires a broad network to access care.
j) Role of Subcontractor	Pharmacy benefits management, vision, and dental

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Pennsylvania (Aetna Better Health Kids)

a) Scope of work and covered benefits	Full scope of CHIP managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	22 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: 1993 Contract remains in effect.
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	Commonwealth of Pennsylvania Department of Insurance Office of CHIP and Adult Basic Lowware Holliman 717-783-1437 lholliman@state.pa.us
f) Number of members served by population type	**CHIP:** 2014: 9,984 2013: 18,762 2012: 26,095 2011: 27,263 2010: 29,136
g) Annual contract payments and description if payment was capitated	**Capitated** 2014 - $21,151,782 2013 - $47,775,236 2012 - $68,464,464 2011 - $62,289,602 2010 - $59,948,848
h) Improvements made in utilization trends and quality indicators	From Dec. 2013- Dec. 2014, inpatient facility utilization/1,000 decreased 29.5% along with mental health inpatient utilization/1,000 decreased 24.5% for the CHIP population.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with the Department of Insurance emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members and integrated care management programs targeting specific conditions such as diabetes and asthma. Additionally, the contract supports appropriate utilization of home health and home-based services and requires a broad network to access care.
j) Role of Subcontractor	Pharmacy benefits management, vision, and dental

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Pennsylvania (Coventry Cares of Pennsylvania)

a) Scope of work and covered benefits	Full scope of Medicaid managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	4 years (SE Zone) 2 years (SW Zone) 1.5 years (New West Zone) 1 year (New East Zone)
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract date: Northeast: 3/1/2013 Northwest: 10/1/2012 West: 10/1/2012 Southwest: 7/1/2012 Contract still in effect
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	Pennsylvania HealthChoices Bureau of Managed Care Liz Deluca 717-772-7395 edeluca@pa.gov
f) Number of members served by population type	**TANF:** 2014: 64,358 2013: 71,220 2012: 35,476 2011: 16,784 2010: 11,707 **ABD**/SSI: 2014: 27,839 2013: 24,435 2012: 12,162 2011: 0 2010:0
g) Annual contract payments and description if payment was capitated	**Capitated** 2014 - $323,038,527 2013 - $348,954,823 2012 - $113,980,755 2011 - $65,263,251 2010 - $25,667,253
h) Improvements made in utilization trends and quality indicators	From Dec. 2013- Dec. 2014, inpatient facility utilization/1,000 decreased 6.5%, mental health inpatient utilization/1,000 decreased 25.7% and emergency department use decreased 2.5%.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with the Pennsylvania HealthChoices emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members and integrated care management programs targeting specific conditions such as diabetes and asthma. Additionally, the contract supports appropriate utilization of home health

Pennsylvania (Coventry Cares of Pennsylvania)

	and home-based services and requires a broad network to access care.
j) Role of Subcontractor	Pharmacy benefits management, vision, and dental

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Texas (Aetna Better Health of Texas)

a) Scope of work and covered benefits	Responsible for the administration of the full scope of Medicaid STAR and CHIP managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	9 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: November 2005 Contract remains in effect.
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	Texas Health and Human Services Commission Rudy Villarreal 512-462-6368 Rudy.Villarreal@hhsc.state.tx.us
f) Number of members served by population type	**TANF:** 2014: 75,674 2013: 58,486 2012: 60,035 2011: 53,727 2010: 45,281 **CHIP:** 2014: 8,113 2013: 12,612 2012: 13,829 2011: 13,225 2010: 11,251
g) Annual contract payments and description if payment was capitated	**Capitated** 2014 - $185,059,573 2013 - $203,210,241 2012 - $198,344,192 2011 - $167,881,110 2010 - $145,631,382
h) Improvements made in utilization trends and quality indicators	From FY 2013-FY 2014, emergency department utilization/1,000 decreased 7.45% along with a reduction in PMPM by 36.63% for the CHIP population. For the same measurement year, the TANF population showed a 11.61% reduction in utilization of inpatient services along with PMPM reduction of 4.03%.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with Texas Health and Human Services Commission emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members and care management programs targeting specific conditions such as diabetes. Additionally, the contract supports appropriate utilization of home health and home-based services and requires a broad network to access care.
j) Role of Subcontractor	Pharmacy benefits management, vision, transportation, dental and behavioral health

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

Virginia (CoventryCares of Virginia)

a) Scope of work and covered benefits	Full scope of Medicaid and CHIP managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	19 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: 1996 Contract remains in effect.
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	DMAS Cheryl Roberts 804-786-6147 cheryl.roberts@dmas.virginia.gov Medallion, FAMIS
f) Number of members served by population type	**TANF:** 2014: 33,776 2013: 30,954 2012: 29,386 2011: 20,504 2010: 19,630 **ABD**/SSI: 2014: 5,369 2013: 4,994 2012: 4,855 2011: 2,7912 2010: 2,689 **CHIP:** 2014: 2,369 2013: 2,359 2012: 2,332 2011: 1,623 2010: 1,488
g) Annual contract payments and description if payment was capitated	**Capitated** 2014 - $127,428,164 2013 - $146,522,787 2012 - $125,142,295 2011 - $86,597,220 2010 - $81,833,642
h) Improvements made in utilization trends and quality indicators	From FY 2013-FY 2014, inpatient facility utilization/1,000 decreased 7.9% for the TANF population. For the same measurement year, the plan showed a reduction in emergency department utilization/1,000 by 10.6% for the CHIP population.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with DMAS emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members and integrated care management programs targeting specific conditions such as diabetes, asthma, CHF and COPD. Additionally, the contract supports appropriate

	utilization of home health and home-based services and requires a broad network to access care.
j) Role of Subcontractor	Pharmacy benefits management, behavioral health, vision, and transportation

Aetna Medicaid affiliate holds the contract directly with the State Medicaid Agency

West Virginia (CoventryCares of West Virginia)

a) Scope of work and covered benefits	Responsible for the administration of the full scope of managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical health services.
b) Duration of the contract	19 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: 1996 Contract remains in effect.
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	West Virginia Medicaid Brandy Pierce 304-558-1700 Brandy.j.pierce@wv.gov
f) Number of members served by population type	**TANF:** 2014: 75,126 2013: 69,776 2012: 63,616 2011: 60,177 2010: 54,775
g) Annual contract payments and description if payment was capitated	**Capitated** 2014 - $199,832,425 2013 - $179,634,931 2012 - $135,271,251 2011 - $127,018,614 2010 - $117,171,293
h) Improvements made in utilization trends and quality indicators	From FY 2013-FY 2014, inpatient facility utilization/1,000 decreased 19.7% for the TANF population. For the same measurement year and population type, the plan showed a 5.2% reduction in emergency department utilization/1,000.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with DMAS emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members and integrated care management programs targeting specific conditions such as diabetes, asthma, CHF and COPD. Additionally, the contract supports appropriate utilization of home health and home-based services and requires a broad network to access care.
j) Role of Subcontractor	Pharmacy benefits management, vision, nurse line and children's dental

Table T6-1: Publicly-Funded Managed Care Contracts for Medicaid, CHIP and other low-income individuals

Aetna Medicaid affiliate provides administrative services to an entity that holds the Medicaid contract with the state agency

Arizona (Mercy Care Plan)

a) Scope of work and covered benefits	Full scope of managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	Health Plan Contract Duration: 30 years Aetna Medicaid Administrators Contract Duration: 13 years (Annual Renewals)
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: 1985 Aetna Medicaid Administrators Contract Start Date: May 2002
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. Aetna is compensated on administrative fee basis for its management services to Mercy Care Plan.
e) Contact name , phone number and e-mail address	Southwest Catholic Health Network Corporation (SCHN) dba Mercy Care Plan Client contact name: Jim Beckmann, Board President 520-872-7796 James.beckmann@carondelet.org State Medicaid Contractor Contact: Diana Alvarez 602-417-4796 Diana.Alvarez@azahcccs.gov
f) Number of members served by population type	**TANF:** 2014: 264,411 2013: 256,039 2012: 265,025 2011: 289,817 2010: 287,793 **ABD**: 2014: 19,093 2013: 38,090 2012: 38,090 2011: 33,441 2010: 18,151
g) Annual contract payments and description if payment was capitated	Mercy Care Plan is paid a capitated rate. Aetna Medicaid as administrator is paid a percentage of Premium Revenue. 2014 - $816,830,306 2013 - $897,310,294 2012 - $911,575,115 2011 - $1,114,791,463 2010 - $1,244,264,411
h) Improvements made in utilization trends and quality indicators	From FY 2013-FY 2014, emergency department utilization/1,000 decreased 5.92% along with an 11.88% decrease in Inpatient Facility services for the ABD population. For the same measurement year, the TANF population showed a 5.2% reduction in inpatient facility

	utilization/1,000.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The Medicaid contract emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, member incentive programs and care management programs targeting specific conditions such as diabetes, asthma, CHF and COPD. Additionally, the contract supports appropriate utilization of home health and home-based services and requires a broad network to access care.
j) Role of Subcontractor	Pharmacy benefits management and vision

Aetna Medicaid affiliate provides administrative services to an entity that holds the Medicaid contract with the state agency

Arizona (Mercy Care Plan)

a) Scope of work and covered benefits	Full scope of managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	Health Plan Contract Duration: 30 years Aetna Medicaid Administrators Contract Duration: 13 years (Annual Renewals)
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: 1985 Aetna Medicaid Administrators Contract Start Date: May 2002
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. Aetna is compensated on administrative fee basis for its management services to Mercy Care Plan.
e) Contact name , phone number and e-mail address	Southwest Catholic Health Network Corporation (SCHN) dba Mercy Care Plan Client contact name: Jim Beckmann, Board President 520-872-7796 James.beckmann@carondelet.org State Medicaid Contractor Contact: Larry Latham 602-542-6857 LLatham@azdes.gov
f) Number of members served by population type	DES/DDD (Individuals enrolled with the Division of Developmental Disabilities): 2014: 9,818 2013: 9,367 2012: 9,202 2011: 8,838 2010: 8,465
g) Annual contract payments and description if payment was capitated	Mercy Care Plan is paid a capitated rate. Aetna Medicaid as administrator is paid a percentage of Premium Revenue. 2014 - $34,244,184 2013 - 439,403,747 2012 - $37,940,741 2011 - $35,934,388 2010 - $35,619,987
h) Improvements made in utilization trends and quality indicators	From FY 2013-FY 2014, emergency department utilization/1,000 decreased 4.46% along with a decrease in inpatient services by 8.13% for the DDD population.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The Medicaid contract) emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, utilization of personal care services, private duty nursing and respite care. Additionally, the contract supports appropriate utilization of home health care services and requires a broad network for members to access care.
j) Role of Subcontractor	Pharmacy benefits management and vision

Aetna Medicaid affiliate provides administrative services to an entity that holds the Medicaid contract with the state agency

Arizona (Mercy Care Advantage)

a) Scope of work and covered benefits	Full scope of Medicare Advantage Special Needs Plan/Dual eligible managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of Medicare and Medicaid mandatory and optional physical and behavioral health services.
b) Duration of the contract	Health Plan Contract Duration: 9 years Aetna Medicaid Administrators Contract Duration: 9 years (Annual Renewals)
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: January 2006 Aetna Medicaid Administrators Contract Start Date: January 2006
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. Aetna is compensated on administrative fee basis for its management services to Mercy Care Advantage.
e) Contact name , phone number and e-mail address	Southwest Catholic Health Network Corporation (SCHN) dba Mercy Care Plan Client name: Jim Beckmann 520-872-7796 James.beckmann@carondelet.org State Medicaid Contractor Contact: Ann Duarte 415-744- 3770 Ann.Duarte@cms.hhs.gov
f) Number of members served by population type	**Medicare Advantage SNP, Dual Eligible Members:** 2014: 13,199 2013: 17,850 2012: 16,804 2011: 15,937 2010: 15,413
g) Annual contract payments and description if payment was capitated	Mercy Care Plan is paid a capitated rate. Aetna Medicaid as administrator is paid a percentage of Premium Revenue. 2014 - $300,874,081 2013 - $333,812,260 2012 - $317,401,212 2011 - $305,712,331 2010 - $274,185,529
h) Improvements made in utilization trends and quality indicators	From FY 2013-FY 2014, emergency department utilization/1,000 decreased 8.32% along with a decrease in inpatient services by 4.93% for the duals population.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The Medicaid contract emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, utilization of personal care services, private duty nursing, coordination of Medicare benefits and respite care. Additionally, the contract supports appropriate utilization of home health care services and requires a broad network for members to access care.
j) Role of Subcontractor	Pharmacy benefits management

Aetna Medicaid affiliate provides administrative services to an entity that holds the Medicaid contract with the state agency

Arizona (Mercy Care Long Term Care)

a) Scope of work and covered benefits	Full scope of managed care services for LTSS members who live in rural areas, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services with a special emphasis on LTSS and HCBS services.
b) Duration of the contract	Health Plan Contract Duration: 14 years Aetna Medicaid Administrators Contract Duration: 12 years (Annual renewals)
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: May 2001 Aetna Medicaid Administrators Contract Start Date: May 2002
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments.
e) Contact name , phone number and e-mail address	Southwest Catholic Health Network Corporation (SCHN) dba Mercy Care Plan Client name: Jim Beckmann 520-872-7796 James.beckmann@carondelet.org State Medicaid Contractor Contact: Diana Alvarez 602-417-4796 Diana.Alvarez@azahcccs.gov
f) Number of members served by population type	**LTSS:** 2014: 12,037 2013: 11,917 2012: 11,449 2011: 9,324 2010: 8,717
g) Annual contract payments and description if payment was capitated	Mercy Care Plan is paid a capitated rate. Aetna Medicaid as administrator is paid a percentage of Premium Revenue. 2014 - $403,901,267 2013 - $466,987,842 2012 - $426,496,723 2011 - $366,328,989 2010 - $362,390,623
h) Improvements made in utilization trends and quality indicators	From FY 2013-FY 2014, inpatient facility utilization/1,000 decreased 16.89% for the LTSS population.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with Southwest Catholic Health Network Corporation (SCHN) emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, utilization of personal care services, private duty nursing and respite care. Additionally, the contract supports appropriate utilization of home health care services and requires a broad network for members to access care.
j) Role of Subcontractor	Pharmacy benefits management and vision

Aetna Medicaid affiliate provides administrative services to an entity that holds the Medicaid contract with the state agency

Arizona (Mercy Healthcare Group)

a) Scope of work and covered benefits	Full scope of managed care services for working uninsured, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical health services.
b) Duration of the contract	Health Plan Contract Duration: 11 years Aetna Medicaid Administrators Contract Duration: 11 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: May 2002 Aetna Medicaid Administrators Contract Start Date: May 2002 Contract end date: December 31, 2013, due to the State Agency ending the program.
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. Aetna is compensated on administrative fee basis for its management services to Mercy Healthcare Group.
e) Contact name , phone number and e-mail address	Southwest Catholic Health Network Corporation (SCHN) dba Mercy Care Plan Client name: Jim Beckmann 520-872-7796 James.beckmann@carondelet.org State Medicaid Contractor Contact: This program is no longer in existence and therefore does not have a specific Contact person. Emailed requests for information can be directed to hcg@hcgaz.com.
f) Number of members served by population type	Working uninsured: 2014: 0 2013:2,365 2012: 2,820 2011: 3,520 2010: 4,522
g) Annual contract payments and description if payment was capitated	Mercy Care Plan was paid a capitated rate. Aetna Medicaid as administrator was paid a percentage of Premium Revenue. 2014 - $165,814 2013 - $8,357,228 2012 - $9,051,379 2011 - $11,138,807 2010 - $18,982,108
h) Improvements made in utilization trends and quality indicators	From December 2012- December 2013, inpatient facility utilization/1,000 decreased 17.5%. For the same measurement year, emergency department utilization decreased by 6.3%
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The Medicaid contract emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members and integrated care management programs targeting specific conditions such as diabetes, CHF and COPD. Additionally, the contract supports appropriate utilization of home health and home-based services and requires a broad network to access care.
j) Role of Subcontractor	Pharmacy benefits management and vision

Aetna Medicaid affiliate provides administrative services to an entity that holds the Medicaid contract with the state agency

Arizona (Mercy Maricopa Integrated Care)

a) Scope of work and covered benefits	Full scope of managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional health services with special emphasis on integration of physical, behavioral health, and Substance Use Disorders services for the Seriously Mentally Ill population.
b) Duration of the contract	Health Plan Contract Duration: 5 months Aetna Medicaid Administrators Contract Duration: 1 year (Annual Renewals)
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: May 1, 2013 Aetna Medicaid Administrators contract start date: May 1, 2013. Operational start date: April 1, 2014
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments.
e) Contact name , phone number and e-mail address	Matt Cox 602-406-6571 matthew.cox@dignityhealth.org
f) Number of members served by population type	**SMI**: 2014: 691,487
g) Annual contract payments and description if payment was capitated	TANF: 2014 - $710,360,861 **ABD**, **SMI*** *new contract; no annualized payments available Mercy Maricopa Integrated Plan is paid a capitated rate. Aetna Medicaid as administrator is paid a percentage of Premium Revenue.
h) Improvements made in utilization trends and quality indicators	New contract, utilization data not available yet.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, a fully integrated behavioral health model and use of peer support services. Additionally, the contract supports appropriate utilization of home health care services and requires a broad network for members to access care.
j) Role of Subcontractor	Pharmacy benefits management, dental, vision, and transportation

Aetna Medicaid affiliate provides administrative services to an entity that holds the Medicaid contract with the state agency

California (Children's' Hospital of Orange County Health Alliance)

a) Scope of work and covered benefits	Full scope of Medicaid and CHIP managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	18 years 7 months
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: October 1995 Contract terminated June 30, 2014 (upon mutual agreement with CHOC) *Aetna Medicaid Administrators provided management services to Children's Hospital of Orange County (CHOC), which held a contract with the State of California.*
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits. Aetna was paid a percentage of premiums for its administrative services.
e) Contact name , phone number and e-mail address	Children's Hospital Orange County (CHOC) and CHOC Physicians Network Alicia Perez 714-509-8354 aperez@choc.org
f) Number of members served by population type	**TANF:** 2014: 0 (January only) 2013: 92,865 2012: 91,470 2011: 88,104 2010: 80,831 **CHIP:** 2014: 0 (January only) 2013: 24,530 2012: 18,673 2011: 18,870 2010: 21,183 **ABD**: 2014: 0 (January only) 2013: 4,850 2012: 4,599 2011: 17,000 2010: 15,797
g) Annual contract payments and description if payment was capitated	2014 (January only) - $9,777,064 2013 - $89,910,323 2012 - $78,283,872 2011 - $79,561,157 2010 - $71,495,089 CHOC Health Alliance was paid a capitated rate. Aetna Medicaid as administrator was paid a percentage of Premium Revenue.
h) Improvements made in utilization trends and quality indicators	From Sept. 2012- Sept. 2013, inpatient facility utilization/1,000 decreased 19.6% with a reduction in PMPM by 18.2%.
i) How the contract emphasizes member choice, access, safety,	The Medicaid contract emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support

independence, and responsibility	continuity of care for all members and care management programs targeting specific conditions such as diabetes and asthma. Additionally, the contract supports appropriate utilization of home health and home-based services and requires a broad network to access care.
j) Role of Subcontractor	Pharmacy benefits management, transportation, vision, dental

Aetna Medicaid affiliate provides administrative services to an entity that holds the Medicaid contract with the state agency

Florida (Integral Quality Care)

a) Scope of work and covered benefits	Full scope of Medicaid managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	3 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: March 2010 Contract ended June 2013 upon mutual agreement.
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	Jennifer Sweet 866-258-4326 jennifer.sweet@integralqualitycare.com State Medicaid Contractor Contact: Kenyatta Smith 850-412-4068 Kenyatta.Smith@ahca.myflorida.com
f) Number of members served by population type	**TANF:** 2014: 0 2013: 31,574 2012: 20,180 2011: 15,619 2010: 6,809 **ABD**: 2014: 0 2013: 3,668 2012: 1,817 2011: 1,358 2010: 929
g) Annual contract payments and description if payment was capitated	2014 - 0 2013 - $45,028,069 2012 - $49,965,376 2011 - $36,884,478 2010 - $14,158,037 Integral Quality Care is paid a capitated rate. Aetna Medicaid as administrator is paid a percentage of Premium Revenue.
h) Improvements made in utilization trends and quality indicators	From Dec. 2011- Dec. 2012, inpatient facility utilization/1,000 decreased 5.5% along with a reduction in PMPM by 13.6%.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with the Agency for Health Care Administration emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members and care management programs targeting specific conditions such as diabetes, asthma, CHF and COPD. Additionally, the contract supports appropriate utilization of home health and home-based services and requires a broad network to access care.
j) Role of Subcontractor	None

Aetna Medicaid affiliate provides administrative services to an entity that holds the Medicaid contract with the state agency

Indiana (Advantage Health Solutions)

a) Scope of work and covered benefits	Provided enhanced Primary Care Case Management program as a subcontractor to Advantage Health Solutions, which contracted directly with the State of Indiana Medicaid program.
b) Duration of the contract	3.5. years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: October 2007 *Aetna Medicaid contract ended on March 31, 2011 upon mutual agreement.*
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the administrative rate was based on membership and periodically changed based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our administrative fee payments to reflect increases and changes in trends, populations, policies and benefits.
e) Contact name , phone number and e-mail address	ADVANTAGE Health Solutions, Inc. Vicki F. Perry 317-573-6571 Vperry@advantageplan.com State Medicaid Contractor Contact: Jill Claypool 317-234-5551 jill.claypool@fssa.in.gov
f) Number of members served by population type	**CHIP/ABD** 2010: 15,089
g) Annual contract payments and description if payment was capitated	2011 - $53,661 2010 - $7,476,528 ADVANTAGE Health Solutions is paid a capitated rate. Aetna Medicaid as administrator is paid a percentage of Premium Revenue.
h) Improvements made in utilization trends and quality indicators	For a rolling 12 month period from Sept 2009- Aug. 2010, the plan showed a 8.1% reduction in inpatient behavioral health admits/1,000.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The contract held with ADVANTAGE Health Solutions emphasized member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, integrated care management programs targeting specific conditions such as diabetes, asthma, CHF and COPD.
j) Role of Subcontractor	None

Aetna Medicaid affiliate provides administrative services to an entity that holds the Medicaid contract with the state agency

Maryland (Maryland Physicians Care)

a) Scope of work and covered benefits	Full scope of Medicaid and CHIP managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	18 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: July 1997
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits. Aetna is paid a percentage of premiums for our administrative services.
e) Contact name , phone number and e-mail address	Maryland Physicians Care Raymond Grahe CEO, Trivergent Health Alliance (301) 790-9131 raymond.grahe@trivergenthealth.com State Medicaid Contractor Contact: Susan Tucker 410-767-1430 susan.tucker@maryland.gov
f) Number of members served by population type	**TANF:** 2014: 136,194 2013: 138,486 2012: 126,688 2011: 115,367 2010: 96,806 **CHIP:** 2014: 19,948 2013: 9,931 2012: 11,818 2011: 11,459 2010: 11,455 **ABD**: 2014: 16,754 2013: 16,373 2012: 17,263 2011: 17,222 2010: 16,575
g) Annual contract payments and description if payment was capitated	2014 - $887,709,151* 2013 - $670,555,666 2012 - $673,252,229 2011 - $650,621,956 2010 - $544,310,982 *forecast, not YTD

	Maryland Physicians Care is paid a capitated rate. Aetna Medicaid as administrator is paid a percentage of Premium
h) Improvements made in utilization trends and quality indicators	From FY 2013-FY 2014, inpatient facility utilization/1,000 decreased 9.14% along with a reduction in PMPM by 7.02% for the ABD population. For the same measurement year, the TANF population showed a reduction in inpatient facility utilization/1,000 by 8.14%.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The Maryland Physicians Care Medicaid contract emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members and integrated care management programs targeting specific conditions such as diabetes, asthma, CHF and COPD. Additionally, the contract supports appropriate utilization of home health and home-based services and requires a broad network to access care.
j) Role of Subcontractor	Pharmacy benefits management, dental, vision, and translation services

Aetna Medicaid affiliate provides administrative services to an entity that holds the Medicaid contract with the state agency

Texas (CHRISTUS Health Plan)

a) Scope of work and covered benefits	Aetna Medicaid is responsible for the administration of the full scope of Medicaid and CHIP managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	4 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: March 2011 Contract expired 2/28/2015
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits. Aetna was paid a percentage of premiums for administrative services.
e) Contact name , phone number and e-mail address	CHRISTUS Health Plan Anita Leal 469-282-2585 Anita.leal@christushealth.org
f) Number of members served by population type	**TANF:** 2014: 7,432 2013: 9,070 2012: 9,075 2011: 0 2010: 0 **CHIP:** 2014: 515 2013: 1,029 2012: 1,306 2011: 0 2010: 0
g) Annual contract payments and description if payment was capitated	2014 - $15,864,029 2013 - $31,411,751 2012 - $22,077,396 2011 - 0 2010 - 0 CHRISTUS Health Plan is paid a capitated rate. Aetna Medicaid as administrator is paid a percentage of Premium Revenue.
h) Improvements made in utilization trends and quality indicators	From Dec. 2013- Dec. 2014, mental health inpatient facility utilization/1,000 decreased 49.4%. For the same measurement year, the plan showed a reduction in emergency department utilization/1,000 by 6.1%.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The CHRISTUS Health Plan contract emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members and integrated care management programs targeting specific conditions such as diabetes and asthma. Additionally, the contract supports appropriate utilization of home health and home-based services and requires a broad network to access care.
j) Role of Subcontractor	Pharmacy benefits management, vision and behavioral health.

Aetna Medicaid affiliate provides administrative services to an entity that holds the Medicaid contract with the state agency

Texas (Parkland Community Health Plan)

a) Scope of work and covered benefits	Medicaid STAR and CHIP managed care services, including operations, partial medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	17 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: December 1998
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s)	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Row G for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits. Aetna is paid a percentage of premiums for administrative services.
e) Contact name , phone number and e-mail address	Parkland Community Health Plan Tim Bahe 214-266-2103 Tim.bahe@phhs.org
f) Number of members served by population type	**TANF:** 2014: 188,412 2013: 163,524 2012: 161,801 2011: 156,317 2010: 183,564 **CHIP:** 2014: 25,974 2013: 40,634 2012: 40,449 2011: 42,021 2010: 0
g) Annual contract payments and description if payment was capitated	2014 - $442,706,339 2013 - $521,429,847 2012 - $515,405,538 2011 - $482,598,208 2010 - $455,481,103 Parkland is paid a capitated rate. Aetna Medicaid as administrator is paid a percentage of Premium Revenue.
h) Improvements made in utilization trends and quality indicators	From FY 2013-FY 2014, inpatient facility utilization/1,000 decreased 33.44% for the TANF population.
i) How the contract emphasizes member choice, access, safety,	The Parkland Community Health Plan Medicaid contract emphasizes member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members and integrated care management programs targeting

independence, and responsibility	specific conditions such as diabetes and asthma. Additionally, the contract supports appropriate utilization of home health and home-based services and requires a broad network to access care.
j) Role of Subcontractor	Pharmacy benefits management, vision, and behavioral health

Aetna Medicaid affiliate provides administrative services to an entity that holds the Medicaid contract with the state agency

Virginia (MajestaCare)

a) Scope of work and covered benefits	Full scope of Medicaid and CHIP managed care services, including operations, medical management, and ancillary support functions (legal, actuarial, and financial management). Covered benefits include full range of mandatory and optional physical and behavioral health services.
b) Duration of the contract	2.5 years
c) Start and end dates of contract as originally entered and any alteration to that timeframe and reason for alteration	Original Contract Start Date: January 1, 2012 After considering many factors, including relatively low membership, Majesta Care plan sponsors made the business decision to terminate the health plan effective November 30, 2014. Run out services are being provided through 1/31/16.
d) Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s).	The value of the contract at execution was unknown, as the capitated rate is based on membership and may periodically change based on cost trends and other variables. Please refer to Column 7 for actual annual payments. The amount of the contract was periodically altered when the State adjusted our capitation payments to reflect increases and changes in trends, populations, policies and benefits. Aetna is paid a percentage of premiums for administrative services.
e) Contact name , phone number and e-mail address	MajestaCare: Carilion Clinic Medicare Resources LLC Donna Littlepage 540-581-0281 dmlittlepage@carilionclinic.org State Medicaid Contractor Contact: Cheryl Roberts 804-786-6147 cheryl.roberts@dmas.virginia.gov
f) Number of members served by population type	**TANF:** 2014: 7,302 2013: 8,492 2012: 6,432 2011: 0 2010: 0 **CHIP:** 2014: 524 2013: 644 2012: 382 2011: 0 2010: 0 **ABD**/DD: 2014: 1,647 2013: 2,010 2012: 1,336 2011: 0 2010: 0
g) Annual contract payments and description if payment was capitated	2014 - $47,180,789 2013 - $51,287,928 2012 - $35,611,447 MajestaCare was paid a capitated rate. Aetna Medicaid as administrator was paid a percentage of Premium Revenue.
h) Improvements made in utilization trends and quality	From Dec. 2013- Dec. 2014, inpatient facility utilization/1,000 decreased 17.8% along with a reduction in emergency department utilization/1,000 by 6.3% for the Roanoke area. For the

indicators	same measurement period, the Far South West region showed a reduction in emergency department utilization/1,000 by 12.7%.
i) How the contract emphasizes member choice, access, safety, independence, and responsibility	The MajestaCare Medicaid contract emphasized member choice, access, safety, independence and responsibility through health education and initiatives, care coordination to support continuity of care for all members, utilization of private duty nursing and integrated care management for targeted conditions such as asthma and diabetes. Additionally, the contract supported appropriate utilization of home health care services and requires a broad network for members to access care.
j) Role of Subcontractor	None

3.2.7.4.2 - Table, Question 2

2. Identify and describe any debarment or suspension, regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity within the last five (5) years.

Aetna Better Health of Iowa Inc. is not yet operational and therefore has no debarments, suspensions, regulatory actions, or monetary or non-monetary sanctions to report.

Debarments, suspensions, regulatory actions, and monetary and non-monetary sanctions imposed by any federal or state regulatory entity in the last five years for health plans administered by Aetna Medicaid that relate to the Medicaid and CHIP services contemplated by this RFP can be found in Table T6-2 titled “Medicaid Regulatory Actions and Sanctions”.

For purposes of the “Applicable Question” column in the table below, please use the following key:

Applicable Question	Reference
3.2.5.4 –Default	List any occurrences where the bidder has either been subject to default or has received notice of default or failure to perform on a contract. Provide full details related to the default or notice of default including the other party’s name, address, and telephone number.
3.2.5.4 –Damages/Fines	List any damages, penalties, disincentives assessed, or payments withheld, or anything of value traded or given up by the bidder under any of its existing or past contracts as it relates to services performed that are similar to the services contemplated by this RFP. Include the estimated cost of that incident to the bidder with the details of the occurrence.
3.2.7.4.2 -Question 2	Identify and describe any debarment or suspension, regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity within the last five (5) years.
3.2.7.4.2 – Question 3	Identify and describe any letter of deficiency issued by or corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relates to Medicare, Medicaid, CHIP, or the Substance Use Disorders Use Prevention and Treatment Block Grant.

Table T6-2: Medicaid Regulatory Actions and Sanctions

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2010	DE/Delaware Physicians Care, Inc.	CAP -Related to subcontractor delegation oversight, provider selection, and case and disease management collaboration.	3.2.5.4 –Default 3.2.7.4.2 -Question 2 3.2.7.4.2 –Question 3	Division of Medicaid and Medical Assistance PO Box 906 New Castle, DE 19720 302-255-9628
2010	Coventry Health Care of Florida and Coventry Health Plan of Florida	Notice of Findings -Required revision of certain policies and procedures, which was completed. No CAP was required.	3.2.7.4.2 –Question 2	N/A
2010	The Diamond Plan (MD)	CAP -EQRO Audit—findings of deficiency.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Health and Mental Hygiene 201 W. Presenton Street Baltimore MD 21201 410-767-3567
2010	CoventryCares of Pennsylvania	CAP -Letter of deficiency for compliance with Executive Management Requirements of the Pennsylvania HealthChoices contract.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Human Services 515 Health and Welfare Building PO Box 2675 Harrisburg, PA 17110-2675 717-787-1870
2010	Aetna Better Health of Texas	Fine (Star Tarrant, CHIP Tarrant, Star Bexar & CHIP Bexar)- $2500 each for failure to submit encounters for BH and Vision.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2010	Aetna Better Health, Inc. (PA CHIP)	Withhold -Received a contract sanction stating capitation was being withheld. Withhold was returned to Plan.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2010	CoventryCares of Michigan	CAP -Staff handbook did not contain the policies and procedures regarding fraud, waste, and abuse by staff, providers, and members.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Michigan Department of Community Health 400 S. Pine Street Lansing, MI 48909 517-335-5289
2010	Aetna Better Health of Texas	Fine (STAR Bexar) -$2500 for failure to meet 98% match by 4% in the Encounters to FSR Paid Claims Input Reconciliation Report.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2010	Aetna Better Health of Texas	Fine (STAR Tarrant)-$2500 for failure to meet 98% match by 1% in the Encounters to FSR Paid Claims Input Reconciliation Report.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2010	Aetna Better Health of Texas	Fine(Star Tarrant, CHIP Tarrant, Star Bexar, CHIP Bexar)-$5000 each for failure to submit encounters.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2010	CHOC Health Alliance	CAP -13 items requiring a CAP in the Annual claims audit for CHOC Physicians Network and CHOC Hospital.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	CalOptima 505 City Parkway West Orange, CA 92868 714-246-8500
2010	Integral Quality Care (Florida)	Fine - $1,000 for late filing of Appeals & Grievance Report.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2010	CHOC Health Alliance	CAP –For four items found partially met in a network oversight audit.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	CalOptima 505 City Parkway West Orange, CA 92868 714-246-8500
2011	Coventry Health Care of Florida, Inc. and Coventry Health Plan of Florida, Inc.	CAP –Relating to onsite review of FWA Program.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Agency for Health Care Administration 2727 Mahan Drive Tallahassee, FL 32308 850-850-4066
2011	Coventry Health Care of Florida, Inc. and Coventry Health Plan of Florida, Inc.	Settlement-$470,000 total for amount health plan repaid to State agency because it was overpaid for claims.	3.2.7.4.2 -Question 2	N/A
2011	The Diamond Plan (MD)	CAP -Findings of deficiency in connection with EQRO audit.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Health and Mental Hygiene 201 W. Presenton Street Baltimore MD 21201 410-767-3567
2011	Parkland Community Health Plan	Fine –$11,000 for falling below the performance standard.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2011	Parkland Community Health Plan	Fine -$10,000 for not meeting Encounter Data benchmarks.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2011	Parkland Community Health Plan and Aetna Better Health, Inc.	Fine –$15,000 for falling below performance standard.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2011	Parkland Community Health Plan	Fine -$1,000 for a marketing violation.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2011	Parkland Community Health Plan	CAP -The PCP error % did not meet the benchmark.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2011	Parkland Community Health Plan	Fine –$5,000 for failure to meet the 98% match in the Encounter to FSR Paid Claims Input Reconciliation Report.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2011	Aetna Better Health of Texas	Fine –$10,000 for failure to meet the 98% match in the Encounter to FSR Paid Claims Input Reconciliation report.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2011	Aetna Better Health of Texas	Fine –$22,500 for not meeting Encounter Data and Claims Processing Performance Requirements benchmarks.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2011	Aetna Better Health of Texas	Fine –$1,000 for non-compliance with performance measures.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2011	Aetna Better Health of Texas	Fine –$22,000 for falling below performance standard.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2011	Maryland Physicians Care	CAP -Related to credentialing file completion documentation and prior authorization.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Health and Mental Hygiene 201 W. Presenton Street Baltimore MD 21201 410-767-3567
2011	Missouri Care Plan	CAP –Related to Behavioral Health Clinical Performance Review.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	MO HealthNet Division 615 Howerton Ct. P.O. Box 6500 Jefferson City, MO 65102-6500 573-751-3425
2011	Integral Quality Care (FL)	Fine –$10,000 for late filing of the anti-fraud plan due to technical issues precluding timely receipt at the State FTP server.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2011	Mercy Care Plan	CAP -Regarding clinical quality performance measures.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Arizona Health Care Cost Containment System (AHCCCS) 801 E. Jefferson Phoenix, AZ 85034 602-417-4000
2011	CHOC Health Alliance	CAP –Relating to four items in Annual claims audit.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	CalOptima 505 City Parkway West Orange, CA 92868 714-246-8500
2011	CHOC Health Alliance	CAP –Relating to findings in The Annual Delegation Oversight Audit that certain standards were not met.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	CalOptima 505 City Parkway West Orange, CA 92868 714-246-8500
2011	CHOC Health Alliance	CAP –Relating to two standards scored as partially met in a focused credentialing audit. The plan scored 98.8% full compliance.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	CalOptima 505 City Parkway West Orange, CA 92868 714-246-8500
2011	Aetna Better Health of Pennsylvania	Fine -$667 for claims processed outside of the contract requirements.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2011	Delaware Physicians Care	CAP -External Quality Review (EQRA) CAP related to appeals and grievance tracking.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Division of Medicaid and Medical Assistance PO Box 906 New Castle, DE 19720 302-255-9628
2011	CoventryCares of Virginia	CAP -One element under Grievance System was partially met due to missing regulatory language.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Medical Assistance Services 600 E. Broad St. Richmond, VA 23219 804-786-7933
2011	Coventry Health Care of Virginia – CareNet	CAP -Reported rates for HEDIS measures fell below the Quality Compass Medicaid (all lines of business) 50th percentile.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Medical Assistance Services 600 E. Broad St. Richmond, VA 23219 804-786-7933

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2012	Aetna Better Health of Illinois	CAP –Relating to ineffectiveness of weekly member inquiries/issues update calls that are regularly held with HFS staff.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	IL Department of Healthcare and Family Services (HFS) 201 South Grand Avenue East Springfield, IL 62763-0002 217-782-0538
2012	Aetna Better Health of Illinois	CAP -Regarding submission of provider affiliation reports, and issues in working, retrieving, and formatting the error reports.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	IL Department of Healthcare and Family Services (HFS) 201 South Grand Avenue East Springfield, IL 62763-0002 217-782-0538
2012	Maryland Physicians Care	Disincentive Penalty –$1.17M relating to two performance measures that fell below target rates.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2012	Coventry Health Care of Florida and Coventry Health Plan of Florida	Fine –$36,500 per entity for failure to meet standards established in an existing Childhood Checkup Corrective Action Plan.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2012	Coventry Health Care of Florida, Inc. and Coventry Health Plan of Florida, Inc.	Fine -$ 10,000 per entity when mental health subcontractor placed a 60-day hold on inpatient admissions creating an access to care issue	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2012	Coventry Health Care of Florida, Inc. and Coventry Health Plan of Florida, Inc.	Letter of Deficiency –Relating to Nursing Home Diversion/Long Term Care Onsite Review.	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2012	Coventry Health Care of Florida and Coventry Health Plan of Florida, Inc.	Fine –$200 per entity for late submission of Claims Aging Report (one day).	3.2.5.4 –Default 3.2.7.4.2 -Question 2	N/A
2012	Coventry Health Care of Florida, Inc. and Coventry Health Plan of Florida, Inc.	Fine –$ 25,000 per entity for late submission of pharmacy encounters data (by one business day).	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2012	Coventry Health Care of Virginia and CoventryCares of Virginia	CAP –Relating to HEDIS measures falling below the Quality Compass Medicaid (all lines of business) 50th percentile.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Medical Assistance Services 600 E. Broad St. Richmond, VA 23219 804-786-7933

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2012	CoventryCares of Virginia	CAP -Improvements in process and timeframes for documenting fraud, waste and abuse activity.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Medical Assistance Services 600 E. Broad St. Richmond, VA 23219 804-786-7933
2012	CoventryCares (HealthAmerica Pennsylvania, Inc.)	CAP -Educational corrective action plan regarding newborn enrollment process.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Human Services 515 Health and 30,000Welfare Building PO Box 2675 Harrisburg, PA 17110-2675 717-787-1870
2012	CoventryCares (HealthAmerica Pennsylvania, Inc.)	CAP –Related to Pharmacy and Vision third party liability reporting.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Human Services 515 Health and Welfare Building PO Box 2675 Harrisburg, PA 17110-2675 717-787-1870
2012	CoventryCares (HealthAmerica Pennsylvania, Inc.)	CAP –Related to findings during the Department of Human Service's Program Integrity Audit.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Human Services 515 Health and Welfare Building PO Box 2675 Harrisburg, PA 17110-2675 717-787-1870
2012	Aetna Better Health of Pennsylvania	CAP –Related to deficiencies in the timeliness and completeness of four transactions in connection with 5010 certification.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Human Services 515 Health and Welfare Building PO Box 2675 Harrisburg, PA 17110-2675 717-787-1870
2012	Aetna Better Health of Pennsylvania	Fine -$667 for claims processing outside of contract requirements.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2012	Aetna Better Health of Pennsylvania	Fine -$6,667 for claims processed outside of contract requirements.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2012	Aetna Better Health of Pennsylvania	Fine -$29,333 for claims processed outside of contract requirements	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2012	Aetna Better Health of Pennsylvania	Fine -$20,667 for claims processed outside of contract requirements.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2012	Aetna Better Health of Pennsylvania	Fine -$4,000 for claims processed outside of contract requirements. Fine waived.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2012	CoventryCares (HealthAmerica Pennsylvania, Inc.)	Fine -Violation of claims processing timeliness for the following time periods: Dec-2011 - $3,333, Jan-2012 - $1,333, May-2012 - $3,667, Jun-2012 - $2,667.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2012	Delaware Physicians Care	CAP -Related to critical incident and quality of care reporting, capture of present on admission (POA) indicator and capture of newborn weight.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Division of Medicaid and Medical Assistance PO Box 906 New Castle, DE 19720 302-255-9628
2012	CoventryCares of West Virginia	CAP -Bureau of Medical Services Quality Improvement Plan not approved by Board of Directors. EQRO Audit for 2011. A corrective action plan requested to address the failure to meet quality standard.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Bureau of Medical Services 350 Capitol Street, Room 251 Charleston, West Virginia 25301 304-356-4912
2012	Aetna Better Health of Texas	Fine –$825 for non-compliance with contract performance measures for our Texas Medicaid risk business.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2012	Aetna Better Health of Texas	Fine (STAR Bexar, CHIP Bexar, STAR Tarrant, and CHIP Tarrant) -$200 each for answering CHIP Hotline calls within 30 seconds 78.63% of the time, instead of meeting the 80% performance standard.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2012	HealthCare USA	CAP -Related to case management functioning more as utilization management than case management and training of staff in connection with review of behavioral health subcontractor.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	MO HealthNet Division 615 Howerton Ct. P.O. Box 6500 Jefferson City, MO 65102-6500 573-751-3425
2013	Aetna Better Health of Illinois	CAP -EQRO review. Related to final readiness report issued about Service Package I—Integrated Care Program implementation readiness review findings.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	IL Department of Healthcare and Family Services (HFS) 201 South Grand Avenue East Springfield, IL 62763-0002 217-782-0538
2013	Aetna Better Health of Illinois	CAP –EQRO review. Related to draft report issued about Service Package II—Long Term Supports and Services. CAP was submitted and pending.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	IL Department of Healthcare and Family Services (HFS) 201 South Grand Avenue East Springfield, IL 62763-0002 217-782-0538

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2013	Coventry Health Care of Florida, Inc. and Coventry Health Plan of Florida, Inc.	Fine –$25,000 each for failure to meet minimum performance measure standards.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2013	Coventry Health Care of Florida, Inc. and Coventry Health Plan of Florida, Inc.	Fine –$1,000 each. Financial statements deemed late because they were in encrypted files that could not be opened by AHCA.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2013	Coventry Health Care of Florida	Fine –1,000 for inaccurate submission of 80/20 by MH vendor.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2013	Coventry Health Care of Florida, Inc. and Coventry Health Plan of Florida, Inc.	Fine –$500 each for late submission of Unaudited Financial Report.	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2013	Coventry Health Care of Florida, Inc. and Coventry Health Plan of Florida, Inc.	Fine –$2,500 each for late submission of CHCUP CAP (one day).	3.2.5.4 –Damages/Fines 3.2.7.4.2 -Question 2	N/A
2013	Delaware Physicians Care	CAP -EQRA CAP related to critical incident reporting, PIP validity, and verbal release of information documentation. PIP is pending.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Division of Medicaid and Medical Assistance PO Box 906 New Castle, DE 19720 302-255-9628
2013	CoventryCares of Kentucky	CAP/Fine –$5,000 for paying 81.32%, instead of the required 90%, of clean claims in 30 days.	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Medicaid Services 275 E. Main St. Frankfort, KY 40621 502-564-9444
2013	CoventryCares of Michigan	CAP -Corrections required to Program Integrity Form to ensure <<See Aetna Style Guide for alternatives>> various sections agree.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Michigan Department of Community Health 400 S. Pine Street Lansing, MI 48909 517-335-5289
2013	CoventryCares of Michigan	CAP -Board of Directors report required identification of member board members.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Michigan Department of Community Health 400 S. Pine Street Lansing, MI 48909 517-335-5289

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2013	CoventryCares of Michigan	PIP –Related to performance monitoring measures falling below standard in connection with Prenatal/Postpartum Care, Well-Child Visits 15 months, Blood Lead Testing and pharmacy encounter data.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Michigan Department of Community Health 400 S. Pine Street Lansing, MI 48909 517-335-5289
2013	MajestaCare	CAP –Related to three HEDIS measures that did not meet the 50th percentile requirement.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Medical Assistance Services 600 East Broad Street Richmond, Virginia 23219 804-786-9092
2013	CHRISTUS Health Plan	CAP/Fine (STAR and CHIP) -$ 300 each because Claim Summary Reports submitted 34 days late, inaccurate or incomplete. Fine paid, CAP pending acceptance.	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	CHRISTUS Health Plan	CAP/Fine -$50 because Provider Termination Report was submitted nine days late, inaccurate, or incomplete. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	CHRISTUS Health Plan	CAP/Fine (STAR & CHIP) -$2,200 each because Network and Specialist Report submitted 88 days late, inaccurate or incomplete. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	CHRISTUS Health Plan	CAP/Fine (STAR & CHIP) -$250 each because Provider Hotline Report was submitted 10 days late, inaccurate or incomplete. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2013	CHRISTUS Health Plan	CAP/Fine -$1,500 because STAR Pharmacy Network Report was submitted 30 days late, inaccurate or incomplete. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	CHRISTUS Health Plan	CAP/Fine -$2,500 because plan billed 21% of total dollars for "other outpatient services" on the Out-of-Network Utilization Report when requirement was no more than 20%. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	CHRISTUS Health Plan	CAP/Fine -$5,000 because STAR Pharmacy encounter reconciliation was 103% when allowable variance is within 2% of the Standard Measure of 100%.	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	CHRISTUS Health Plan	CAP/Fine -$1,600 because CHIP Behavioral Health Claims Summary Reports were submitted 8 days late, inaccurate, or incomplete.	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	CHRISTUS Health Plan	CAP/Fine -$25 because CHIP Behavioral Health Crisis Hotline Report submitted one day late, inaccurate, or incomplete. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	CHRISTUS Health Plan	CAP/Fine -$2,500 because MCO's hospital admissions totaled 17.60% on the Out-of-Network Utilization Report when requirement was no more than 15%. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2013	CHRISTUS Health Plan	CAP/Fine -$2,500 because plan billed 21.30% of total dollars for "other outpatient services" on the Out-of-Network Utilization Report when requirement was no more than 20%. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	CHRISTUS Health Plan	CAP/Fine -$ 200 because STAR "Charlies Place" reports were submitted eight days late, inaccurate, or incomplete. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Parkland Community Health Plan	CAP/Fine -$4,400 because Specialist Network Report was submitted 88 days late, inaccurate or incomplete. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Parkland Community Health Plan	CAP/Fine -$325 because MC Provider Termination Report was submitted 13 days late, inaccurate or incomplete. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Parkland Community Health Plan	CAP/Fine -$500 because STAR Acute Claims Summary Report was submitted five days late, inaccurate, or incomplete. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2013	Parkland Community Health Plan	CAP/Fine –S$4,350 because STAR Specialist Network Report was submitted 87 days late, inaccurate or incomplete. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Parkland Community Health Plan	CA/ Fine -$600 because STAR Financial Statistical Reports were submitted six days late, inaccurate, or incomplete. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Parkland Community Health Plan	CAP/Fine -$6,150 because Certificate of Insurance was submitted 123 days late, inaccurate or incomplete. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Parkland Community Health Plan	CAP/Fine -$525 because STAR Member Appeals Reports were submitted 21 days late, inaccurate or incomplete. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Parkland Community Health Plan	CAP/Fine (STAR & CHIP) -$500 each for prohibited marketing practices. Fines paid, CAPs pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Aetna Better Health of Texas	CAP/Fine -$8,800 because provider P92 files were submitted 88 days late, inaccurate or incomplete.	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2013	Aetna Better Health of Texas	CAP/Fine -$8,800 because provider P94 files were submitted 88 days late, inaccurate or incomplete.	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Aetna Better Health of Texas	CAP -Member Hotline reports were submitted 2 days late, inaccurate or incomplete. CAP pending acceptance	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Aetna Better Health of Texas	CAP -Provider Hotline reports were submitted 2 days late, inaccurate or incomplete. CAP pending acceptance	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Aetna Better Health of Texas	CAP/Fine –$850 because STAR Bexar Provider Termination reports were submitted 34 days late, inaccurate or incomplete. Fine paid and CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Aetna Better Health of Texas	CAP/Fine -$750 because STAR Tarrant Provider Termination reports were submitted 30 days late, inaccurate or incomplete. Fine paid and CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2013	Aetna Better Health of Texas	CAP -Behavioral Health Hotline Crisis Call reports were submitted 73 days late, inaccurate or incomplete. CAP pending acceptance	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Aetna Better Health of Texas	CAP/Fine -$1,000 because Medical Encounter performance of 85% and did not fall within the allowable 2% variance from the standard measure of 100%. Fine paid and CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Aetna Better Health of Texas	CAP -Pharmacy encounters performance of 87% did not fall within the allowable 2% variance from the standard measure of 100$. CAP pending acceptance	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Aetna Better Health of Texas	CAP/Fine -$250 because MCO Medical encounters performance of 91% did not fall within the allowable 2% variance from the standard measure of 100%. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Aetna Better Health of Texas	CAP -CHIP Behavioral Health Claims processing performance was 97.34% when requirement was that MCO process 98% of all Clean Claims within 30 days of receipt. CAP pending acceptance	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Aetna Better Health of Texas	CAP -STAR Behavioral Health Claims processing performance was 97.14% when requirement was that MCO adjudicate 98% of all Clean Claims within 30 days of receipt. CAP pending acceptance	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2013	Aetna Better Health of Texas	CAP/Fine -$3,600 because Vision Claim Summary Reports were submitted nine days late, inaccurate, or incomplete. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Aetna Better Health of Texas	CAP -Acute Claim Summary Reports were submitted two days late, inaccurate, or incomplete. CAP pending acceptance	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Aetna Better Health of Texas	CAP/Fine (STAR & CHIP) –$200 each because Pharmacy Claims Lag Reports were submitted four days late, inaccurate, or incomplete. Fines paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Aetna Better Health of Texas	CAP/Fine -$500 because Pharmacy Claims Summary Reports were submitted 20 days late, inaccurate or incomplete. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Aetna Better Health of Texas	CAP/Fine -$3,450 because CHIP Claims Summary Reports were submitted 69 days late, inaccurate or incomplete. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2013	Aetna Better Health of Texas	CAP & Fine -$2,500 because Pharmacy Encounters performance was 104.00% when allowable variance was within 2% from the Standard Measure of 100%. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Aetna Better Health of Texas	CAP/Fine (STAR & CHIP) -$2,000 because Financial Statistical Reports were submitted 20 days late, inaccurate or incomplete. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Aetna Better Health of Texas	CAP/Fine -$10,000 for failure to provide notice of required coverage. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Aetna Better Health of Texas	CAP/Fine -$5,000 because CHIP Pharmacy Encounters performance was 103.00% when allowable variance is within 2% from the standard measure of 100%. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	Aetna Better Health of Texas	CAP/Fine -$2,500 because STAR Pharmacy Encounters performance was 103.00% when allowable variance is within 2% from the Standard Measure of 100%. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2013	CoventryCares of Virginia	CAP -Rates for HEDIS measures fell below the Quality Compass Medicaid (all lines of business) 50th percentile.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Medical Assistance Services 600 E. Broad St. Richmond, VA 23219 804-786-7933

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2013	Aetna Better Health of New York	Letter of Deficiency -- February and March 2013 letters from the NYDOH inquiring about deficiencies in the Health Plan Network Submission. Response submitted, closed.	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2013	Aetna Better Health of New York	Withhold --$800,000 of PMPM requested to be returned due to alleged improper enrollment and care management of Members. Withhold pending during stipulated settlement discussions.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2013	Mercy Care Plan	CAP –Imposed by AHCCCS related to the volume of pended encounters over 120 days.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Arizona Health Care Cost Containment System (AHCCCS) 801 E. Jefferson Phoenix, AZ 85034 602-417-4000
2013	Mercy Care Plan	CAP –Imposed by DDD related to the volume of pended encounters over 120 days.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Developmental Disabilities 3443 N. Central Ave., Suite 600 Site Code 795M PO Box 6123 Phoenix, AZ 85005 602-771-8080
2013	Mercy Care Plan	Fine -$216,717 imposed by AHCCCS for the volume of pended encounters over 120 days for the timeframe ending 3rd Quarter 2013.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2013	Mercy Care Plan	Fine -$6,975 imposed by DDD for the volume of pended encounters over 120 days for the timeframe ending 3rd Quarter 2013.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2013	CoventryCares (HealthAmerica Pennsylvania, Inc.)	CAP -Related to long-term care encounters not being submitted.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Human Services 515 Health and Welfare Building PO Box 2675 Harrisburg, PA 17110-2675 717-787-1870
2013	Aetna Better Health of Pennsylvania	CAP –Related to findings during a Program Integrity Audit.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Human Services 515 Health and Welfare Building PO Box 2675 Harrisburg, PA 17110-2675 717-787-1870

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2013	HealthCare USA	CAP –Review of the behavioral health subcontractor found case management functioning more as utilization management than case management and the need for staff training to address this.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	MO HealthNet Division 615 Howerton Ct. P.O. Box 6500 Jefferson City, MO 65102-6500
2014	Mercy Care Plan	Fine -$56,240 for the volume of pended encounters over 120 days for the timeframe ending 4th Quarter 2013.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2014	Mercy Care Plan	Fine -$6,325 imposed by DDD for the volume of pended encounters over 120 days for the timeframe ending 4th Quarter 2013.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2014	Mercy Care Plan	Fine -$6,930 imposed by AHCCS for volume of pended encounters over 120 days for the timeframe ending 1st Quarter 2014.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2014	Mercy Care Plan	Fine -$5,470 imposed by DDD for volume of pended encounters over 120 days for the timeframe ending first quarter 2014.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2014	Mercy Care Plan	Fine -$150,000. AHCCCS notified Plan of intent to sanction it for three quality measurements (Well-Child Visits, first 15 months; Adolescent Well Care; EPSDT Participation). Plan's appeal pending.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question2	N/A
2014	Aetna Better Health of Nebraska	Letter of Deficiency – Related to State's encounter submission rate.	3.2.7.4.2 _Question 2 3.2.7.4.2 –Question 3	N/A
2014	CoventryCares of Pennsylvania	CAP -Related to wording in complaint/grievance decision letters.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Human Services 515 Health and Welfare Building PO Box 2675 Harrisburg, PA 17110-2675 717-787-1870
2014	CoventryCares of Pennsylvania	CAP -Related to delegation oversight of DentaQuest in the New East Zone.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Human Services 515 Health and Welfare Building PO Box 2675 Harrisburg, PA 17110-2675 717-787-1870
2014	Aetna Better Health, Inc. (PA CHIP)	CAP –Related to findings that the income calculation utilized in determining eligibility was not done according to Pennsylvania's CHIP Policy & Procedure Manual. CAP pending	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Pennsylvania Insurance Department 1142 Strawberry Square Harrisburg, PA 17120 717-705-0009
2014	Coventry Health Care of Florida	Fine -$1,750 for provider network file rejection.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2014	Coventry Health Care of Florida and Coventry Health Plan of Florida	Fine -$500 each for failure to use required attestation template.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2014	Coventry Health Care of Florida	Fine -$2,500 reduced from $247,500 for failure to comply with the Medicaid contract marketing requirements.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2014	Coventry Health Care of Florida	Fine -$30,000 because behavioral health subcontractor's internal system error caused incorrect denials for Statewide Inpatient Psychiatric Program (SIPP) claims.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2014	Aetna Better Health of Texas and Parkland Community Health Plan	CAP –Relating to checkup participation rates. CAP pending acceptance	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2014	CoventryCares of Kentucky	CAP -Related to grievance and appeals notifications and claims processing errors.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Medicaid Services 275 E. Main St. Frankfort, KY 40621 502-564-9444
2014	CoventryCares of Kentucky	Letter of Deficiency –For submission of 63 encounter files labeled as originals, which included adjustment files as well. Closed	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2014	CoventryCares of Kentucky	PIP –For failure to submit notifications about discontinuance of services for foster children in residential facilities within the 48-hour notification timeframe.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Medicaid Services 275 E. Main St. Frankfort, KY 40621 502-564-9444
2014	CoventryCares of Kentucky	Letter of Deficiency –Supplemental Payments to PCPs for ACA enhanced reimbursement not completed promptly. Closed.	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2014	CoventryCares of Kentucky	CAP –Relating to failure to include a date on a Notice of Action to a member and copy provider.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Medicaid Services 275 E. Main St. Frankfort, KY 40621 502-564-9444
2014	CoventryCares of Kentucky	Fine -$9,500 for improper submission of encounters. In addition to the fine, withholds were originally withheld but returned to the plan.	3.2.5.4 -Damages/Fines 3.2.7.4.2 –Question 2	N/A

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2014	CoventryCares of Kentucky	Fine –$16,500 for improper submission of encounters. In addition to the fine, withholds were originally withheld but returned to the plan.	3.2.5.4 -Damages/Fines 3.2.7.4.2 –Question 2	N/A
2014	CoventryCares of Kentucky	Fine -$59,000 ($19,000 late fees/$40,000 for threshold errors) for improper submission of encounters.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question2	N/A
2014	CoventryCares of Kentucky	Fine -$48,000 for improper submission of encounters. In addition to the fine, withholds were originally withheld but returned to the plan.	3.2.5.4 -Damages/Fines 3.2.7.4.2 –Question 2	N/A
2014	CoventryCares of Kentucky	CAP -IPRO Findings for EQRO annual review related to incomplete HRAs, Stratification of DCBS population, updated Member rights policies, and updated member and provider manuals.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Medicaid Services 275 E. Main St. Frankfort, KY 40621 502-564-9444
2014	CoventryCares of Michigan	CAP -Monthly report evidencing member ID cards and new member packets are mailed within 10 days of the month's enrollment file.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Michigan Department of Community Health 400 S. Pine Street Lansing, MI 48909 517-335-5289
2014	CoventryCares of Michigan	CAP -Corrections required to Program Integrity Form to ensure <<See Aetna Style Guide for alternatives>> various sections agree.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Michigan Department of Community Health 400 S. Pine Street Lansing, MI 48909 517-335-5289
2014	CoventryCares of Michigan	CAP -Submission of surveys or access studies demonstrating covered services required to be available 24 hours a day and seven days a week.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Michigan Department of Community Health 400 S. Pine Street Lansing, MI 48909 517-335-5289
2014	CoventryCares of Michigan	CAP -Policy and procedures required to be submitted addressing beneficial ownership of 5% or more.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Michigan Department of Community Health 400 S. Pine Street Lansing, MI 48909 517-335-5289

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2014	CoventryCares of Michigan	CAP -Reporting required demonstrating that member ID cards and member packets are sent within 10 business days of the monthly enrollment audit file.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Michigan Department of Community Health 400 S. Pine Street Lansing, MI 48909 517-335-5289
2014	CoventryCares of Michigan	CAP -Member handbook to be revised for October 2013 contract changes.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Michigan Department of Community Health 400 S. Pine Street Lansing, MI 48909 517-335-5289
2014	CoventryCares of Michigan	CAP –To address various scores for the well child performance monitoring measures falling below standard.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Michigan Department of Community Health 400 S. Pine Street Lansing, MI 48909 517-335-5289
2014	CoventryCares of West Virginia	CAP – Dental vendor initially sanctioned and sent a CAP for failure to pay some providers within the required 30 days. On appeal, the sanction was removed and the CAP was upheld.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Bureau of Medical Services 350 Capitol Street, Room 251 Charleston, West Virginia 25301 304- 356-4912
2014	CoventryCares of West Virginia	CAP –Related to elements not fully met in the Systems Performance Review (SPR) during an EQRO. CAP accepted and pending closure	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Bureau of Medical Services 350 Capitol Street, Room 251 Charleston, West Virginia 25301 304- 356-4912
2014	Aetna Better Health of Texas	Fine (STAR Bexar CHIP Bexar and Tarrant) -$200 each because Pharmacy Network Reports were submitted eight days late, inaccurate, or incomplete.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question2	N/A
2014	Aetna Better Health of Texas	Fine -$2,500 STAR Pharmacy Encounters performance was 103.00% when allowable variance is within 2% from the Standard Measure of 100%.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2014	Aetna Better Health of Texas	Letter of Deficiency -CHIP Tarrant Pharmacy Encounters performance was 118.00%. Allowable variance is within 2% from the Standard Measure of 100%. Closed	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2014	Aetna Better Health of Texas	Letter of Deficiency -CHIP Bexar Pharmacy Encounters performance was 117.00%. Allowable variance is within 2% from the Standard Measure of 100%. Closed.	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2014	Aetna Better Health of Texas	CAP/Fine -$600 because 73.68% of Member Hotline calls were answered within 30 seconds when 80% answer rate was required.	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2014	Aetna Better Health of Texas	CAP/Fine -$1,000 because Spanish section of plan website was not functional.	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2014	Aetna Better Health of Texas	Letter of Deficiency -Provider Hotline Reports were submitted one day late, inaccurate, or incomplete. No sanctions imposed.	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2014	Aetna Better Health of Texas	Fine -$1,000 because Plan updated website without approval.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question2	N/A
2014	Aetna Better Health of Texas	CAP/Fine -STAR Behavioral Health Claims processing performance was 97.29% when MCO requirement was to adjudicate 98% of all Clean Claims within 30 days of receipt.	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2014	Aetna Better Health of Texas	Letter of Deficiency (STAR Bexar, CHIP Bexar, STAR Tarrant, CHIP Tarrant) -Behavioral Health Crisis Hotline call abandonment rate requirement was 7% and plan performance was 9.09%. Closed	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2014	Aetna Better Health of Texas	Letter of Deficiency (STAR Bexar, CHIP Bexar, STAR Tarrant, CHIP Tarrant) –Financial Statistical Report was considered 2 days late due to being submitted on an outdated version. Closed	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2014	Aetna Better Health of Texas	CAP/Fine -$1000 because Plan Pharmacy Encounters performance was 104% when the allowable variance is within 2% from the Standard Measure of 100% Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2014	Aetna Better Health of Texas	CAP (CHIP Bexar & CHIP Tarrant) –Plan Pharmacy Encounters performance was 104% when the allowable variance is within 2% from the Standard Measure of 100% CAP pending acceptance	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2014	Aetna Better Health of Texas	CAP/Fine (STAR Tarrant) –$250 because Plan Pharmacy Encounters performance was 104% when the allowable variance is within 2% from the Standard Measure of 100%. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2014	Aetna Better Health of Texas	Fine (STAR Bexar and Tarrant) -$1,500 because Frew Medicaid Texas Health Steps (THSteps) Medical Checkups Report submitted 15 days late, inaccurate, and incomplete.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2014	Aetna Better Health of Texas	Fine (STAR Bexar and Tarrant) -$1,300 because Frew Quarterly Monitoring Report submitted 13 days late, inaccurate, and incomplete.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question2	N/A
2014	Aetna Better Health of Texas	Fine (STAR Bexar and Tarrant)-$300 because Frew Provider Recognition Report submitted 3 days late, inaccurate, and incomplete.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2014	Aetna Better Health of Texas	Fine (STAR Bexar and Tarrant) -$1,200 because Frew Quarterly Monitoring Report was submitted 6 days late, inaccurate, and incomplete.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2014	Aetna Better Health of Texas	Fine (STAR Bexar and Tarrant) -$4,000 Frew Quarterly Monitoring Report submitted 4 days late, inaccurate, and incomplete.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2014	Aetna Better Health of Texas	Disincentive/CAP -$691,695 ($308,845 in recouped capitation payments and $ 382,850 in applied disincentives) for failure to achieve the required checkup participation rates for new or existing members. CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2014	CHRISTUS Health Plan	Letter of Deficiency (CHIP & STAR) -Financial Statistical Reports considered 7 days late due to submission on outdated version. Closed	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2014	CHRISTUS Health Plan	Letter of Deficiency (CHIP) –Plan Pharmacy Encounters were at 104% when allowable variance is within 2% from the standard measure of 100%. Closed	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2014	CHRISTUS Health Plan	Fine (STAR) –$5,000 because Plan Pharmacy Encounters were at 104% when allowable variance is within 2% from the standard measure of 100%.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question2	N/A
2014	CHRISTUS Health Plan	Fine -$800 because Frew Annual Provider Training Report was considered 8 days late, inaccurate, and incomplete.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2014	CHRISTUS Health Plan	Fine -$300 because Frew Provider Recognition Report was considered 3 days late, inaccurate, and incomplete.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2014	CHRISTUS Health Plan	Fine -$700 Frew Quarterly Monitoring Report considered 7 days late, inaccurate, and incomplete.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question2	N/A
2014	CHRISTUS Health Plan	Letter of Deficiency –85.71% of appealed claims were adjudicated within required 30 days when contract requirement was 98%. Closed	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2014	CHRISTUS Health Plan	Fine -$1,000 because Plan website went live without approval.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question2	N/A
2014	CHRISTUS Health Plan	Fine -$1,000 because Spanish version of website not available.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2014	CHRISTUS Health Plan	Letter of Deficiency -CHIP Pharmacy Encounters performance was 96% when the allowable variance is within 2% from the Standard Measure of 100%. Closed	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2014	Parkland Community Health Plan	Fine -$40 because 75.55% of Member Hotline calls were answered within 30 seconds when required answer rate was 80%	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2014	Parkland Community Health Plan	Fine -$25 because Provider Hotline Reports were submitted one day late, inaccurate, or incomplete.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2014	Parkland Community Health Plan	Fine -$50 because 95% of member appeals were resolved within 30 calendar days when the required resolution rate was 98%.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question2	N/A
2014	Parkland Community Health Plan	Disincentive/CAP -$136,230 for failure to achieve the required checkup participation rates for new members. CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2014	Parkland Community Health Plan	Fine -$200 because Frew Medicaid Texas Health Steps (THSteps) Medical Checkups Report considered 2 days late, inaccurate, and incomplete.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2014	Parkland Community Health Plan	Fine -$2,100 because Frew Annual Provider Training Report was considered 21 days late, inaccurate, and incomplete.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2014	CoventryCares of Virginia	Letter of Deficiency -Program Integrity Audit for 2013: Deficiencies noted on one of 12 standards – Internal Monitoring & Audit, requiring improved level of specific scheduled audits in addition to current use of Fraud, Waste, and Abuse (FWA) identification software. Plan awaiting State's response to PI audit plan.	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2014	CoventryCares of Virginia	CAP -One element under Grievance Systems was partially met due to missing regulatory language.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Medical Assistance Services 600 E. Broad St. Richmond, VA 23219 804-786-7933
2014	Aetna Better Health of Ohio	CAP –Relating to failure of all LTSS and Member Services Leadership to attend ODM incident training in person.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Ohio Department of Medicaid 500 West Town Street, Suite 400 Columbus, OH 43215 614-752-4000
2014	Aetna Better Health of Ohio	CAP –Relating to failure to meet contractual Call Center standards for certain call center metrics. CAP pending acceptance	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Ohio Department of Medicaid 500 West Town Street, Suite 400 Columbus, OH 43215 614-752-4000

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2014	Aetna Better Health of Ohio	CAP –Relating to failure to provide transition and ongoing services for waiver consumers who have elected self-directed employer authority through state-required vendor.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Ohio Department of Medicaid 500 West Town Street, Suite 400 Columbus, OH 43215 614-752-4000
2014	Aetna Better Health of Ohio	PIP -Relating to progress in completing initial comprehensive assessments.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Ohio Department of Medicaid 500 West Town Street, Suite 400 Columbus, OH 43215 614-752-4000
2014	Aetna Better Health of Ohio	Letter of Deficiency –Regarding inadvertent direct contact with the state's contractor Mercer. The plan instructed not to make contacts with contractor. Closed	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2014	Mercy Care Plan	CAP –Related to quarterly financial reporting inaccuracies. CAP pending acceptance	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Arizona Health Care Cost Containment System (AHCCCS) 801 E. Jefferson Phoenix, AZ 85034 602-417-4000
2014	Mercy Maricopa Integrated Care	Letter of Deficiency (Notice to Cure) –For failure to meet three telephone performance standards. Closed.	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2014	Mercy Maricopa Integrated Care	Letter of Deficiency (Letter of Concern) –For failure to meet the minimum performance standard of 98% or greater for timeliness of prior authorization requests. Open.	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2014	Mercy Maricopa Integrated Care	CAP -Related to the coordination of medication and pharmacy benefits during the transition of members to the plan.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	ADHS/DBHS 150 N. 18th Avenue, 2nd Floor Phoenix, AZ 85007 602-364-4558
2014	Mercy Maricopa Integrated Care	CAP –Regarding Mercy Maricopa's timely notification to members concerning material changes to the network. CAP pending acceptance	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	ADHS/DBHS 150 N. 18th Avenue, 2nd Floor Phoenix, AZ 85007 602-364-4558
2014	Mercy Maricopa Integrated Care	Letter of Deficiency(Letter of Concern) –Relating to crisis services provided and reporting of hospital hold data. Plan has taken steps to reduce hospital hold percentages.	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2014	Mercy Maricopa Integrated Care	Letter of Deficiency -Regarding Mercy Maricopa's monitoring and reporting of Seclusion and Restraint (SAR). Closed.	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2014	Mercy Maricopa Integrated Care	CAP – Relating to Pharmacy Authorization.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	ADHS/DBHS 150 N. 18th Avenue, 2nd Floor Phoenix, AZ 85007 602-364-4558
2014	Mercy Maricopa Integrated Care	Letter of Concern –Stating that certain key operational functions could not be delegated or subcontracted in a comprehensive management services agreement.	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2014	Mercy Maricopa Integrated Care	CAP -Regarding Mercy Maricopa's timely notification to members concerning material changes to the network.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	ADHS/DBHS 150 N. 18th Avenue, 2nd Floor Phoenix, AZ 85007 602-364-4558
2014	Aetna Better Health of Illinois	Letter of Deficiency -HSAG, EQRO vendor, submitted their report of additional items being requested from the July 2014 FHP/ACA readiness review. The HSAG report was reviewed and listing of 25 open issues referenced in the report were collected and forwarded to the state for review.	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2014	HealthCare USA	CAP –For inaccuracies in online provider directories.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	MO HealthNet Division 615 Howerton Ct. P.O. Box 6500 Jefferson City, MO 65102-6500 573-751-3425
2014	HealthCare USA	CAP -Requesting one language addition in the fraud, waste, and abuse plan regarding provider recoupments related to fraud after the plan has reported the expense in cost reports used to set rates.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	MO HealthNet Division 615 Howerton Ct. P.O. Box 6500 Jefferson City, MO 65102-6500
2014	Mercy Care Plan	Fine -$3,275.00 by AHCCCS for the number of pended encounters over 120 days.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2014	Mercy Care Plan	Fine -$840.00 by DDD for the volume of pended encounters over 120 days.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question2	N/A

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2014	CoventryCares of Virginia	CAP -For 4 HEDIS measures that did not meet the required 50th percentile.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Medical Assistance Services 600 E. Broad St. Richmond, VA 23219 804-786-7933
2014	CoventryCares of Virginia	CAP -All MCO's for Virginia were required to submit CAP regarding results of EQRO vendor review of assessments of children with special health care needs. The percentage of CoventryCares CSHCN assessments containing all six required components was 98% and the MCO scored 100% for five of the six components.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Medical Assistance Services 600 E. Broad St. Richmond, VA 23219 804-786-7933
2014	Coventry Health Care of Florida	Fine -$1,000.00 for the late submission of a Long-Term Care Program report.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	NA
2015	CoventryCares of Virginia	Withhold -$32,078.82 For to cost incurred to correct duplicate encounter submissions.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question2	N/A
2015	Mercy Care Plan	Fine -$640.00 by DDD for the number of pended encounters over 120 days	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2015	Mercy Care Plan	Fine -$1,210.00 by AHCCCS fine for the number of pended encounters over 120 days.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2015	Mercy Care Plan	Letter of Deficiency (Notice to Cure) -AHCCCS sent for non-compliance by a vendor for non-emergency transportation services.	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2015	Aetna Better Health of Ohio	CAP - For failure to meet contractual and American Accreditation HealthCare Commission/URAC Health Call Center standards in the member services toll-free call-in system. CAP pending acceptance	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Ohio Department of Medicaid 500 West Town Street, Suite 400 Columbus, OH 43215 614-752-4000
2015	Aetna Better Health of Ohio	Letter of Deficiency (Notice of Noncompliance) -For failure to timely mail all required 2015 marketing materials to members passively enrolled for both Medicare and Medicaid effective 1/1/2015. The regulators replaced NONC with a revised NONC. The revised NONC will impact plan's CMS past performance scorecard for 2015 and 2016. The revised NONC is considered by CMS both a Part C and a Part D issue with beneficiary impact.	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2015	Aetna Better Health of Ohio	CAP –For reporting of fewer Alerts than other plans. CAP pending acceptance	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Ohio Department of Medicaid 500 West Town Street, Suite 400 Columbus, OH 43215 614-752-4000
2015	Aetna Better Health of Ohio	CAP For failure to meet abandonment rate requirements for the member services toll-free call in. CAP pending acceptance	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Ohio Department of Medicaid 500 West Town Street, Suite 400 Columbus, OH 43215 614-752-4000
2015	Aetna Better Health of Ohio	CAP/Fine -$5,000 for ODM assessed a 5 point penalty for failure to timely mail 2015 marketing materials and imposed $5,000 fine as a result of plan having total points between16-25. Fine paid, CAP pending acceptance	3.2.5.4 –Default 3.2.5.4 –Damages/Fine 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Ohio Department of Medicaid 500 West Town Street, Suite 400 Columbus, OH 43215 614-752-4000
2015	CoventryCares of West Virginia	Fine -$7.39 for late renewal of business license.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2015	Mercy Maricopa Integrated Care	Letter of Deficiency (Letter of Concern): Due to lower rate of service delivery compared to other GSAs statewide with respect to Comprehensive Medical and Dental Program (CMDP) Behavioral Health Service Penetration Rates. Open.	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2015	Mercy Maricopa Integrated Care	Letter of Deficiency (Notice to Cure) -Regarding the provision of timely non-emergency medically necessary transportation services as a result of the transition to Logisticare.	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2014	Mercy Maricopa Integrated Care	CAP -Regarding ongoing deficiencies associated with accurate and complete Utilization Management /Medical Management (UM/MM) data submissions.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	ADHS/DBHS 150 N. 18th Avenue, 2nd Floor Phoenix, AZ 85007 602-364-4558
2014	Mercy Maricopa Integrated Care	Letter of Deficiency (Letter of Concern) -Regarding integrated health care service delivery for members determined to have a Serious Mental Illness (SMI).	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2015	Mercy Maricopa Integrated Care	Letter of Deficiency (Notice to Cure) -Regarding ongoing performance deficiencies with MM/UM data file submissions.	3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	N/A
2015	Mercy Maricopa Integrated Care	Fine -$1000 because Prior Authorization report was rejected for exceeding the 5% error threshold. Payment pending	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question2	N/A
2015	Mercy Maricopa Integrated Care	Fine -$1000 for an incomplete submission of the Pharmacy Utilization report. Payment pending	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question2	N/A

Year	Company	Description of action and Estimated Cost, If Applicable	Applicable Question	Name, Address and Phone Number of Other Party, if applicable
2015	Mercy Maricopa Integrated Care	Fine -$3000 for an untimely deliverable (MM/UM Over Under-utilization report).	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question2	N/A
2015	Mercy Maricopa Integrated Care	Fine -$100,000 for failure to ensure <<See Aetna Style Guide for alternatives>> and coordinate timely and adequate non-emergency medically necessary transportation as a result of the transition to Logisticare. Payment pending	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question2	N/A
2015	Aetna Better Health of Texas	CAP –Relating to checkup participation rates for Frew timely checkups. Medical Checkup Reports for new and existing members in the Bexar and Tarrant Service Areas were as follows: Bexar:40.43% and 38.21%; Tarrant: 40.95% and 37.01%, but required checkup participation rates are at least 50% of new and existing members, birth through age 20.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2015	Parkland Community Health Plan	CAP –Relating to checkup participation rates for Frew timely checkups. Medical checkup participation rates for new and existing members in the Dallas Service Area are were: 48.51% and 52.64%, but required rates for new and existing members' birth through age 20, is at least 50%.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Health & Human Services Commission (HHSC) 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 512-424-6500
2015	CoventryCares of Kentucky	Fine -$48,500 for failure to submit encounters as required.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question2	N/A
2015	CoventryCares of Kentucky	CAP –Regarding timely ACA payments to FQHC/RHCs.	3.2.5.4 –Default 3.2.7.4.2 –Question 2 3.2.7.4.2 –Question 3	Department of Medicaid Services 275 E. Main St. Frankfort, KY 40621 502-564-9444
2015	CoventryCares of Kentucky	Fine -$48,000(timely submission $11,000 and threshold errors $37,000) for failure to submit encounters as required.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question2	N/A
2015	Coventry Health Care of Florida	Fine -$500 because the PBM sent materials not approved by the state to members.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question 2	N/A
2015	Coventry Health Care of Florida	Fine -$500 for failure to submit the case management monitoring and evaluation report timely.	3.2.5.4 –Damages/Fines 3.2.7.4.2 –Question2	N/A

3.2.7.4.2 - Table, Question 3

3. Identify and describe any letter of deficiency issued by or corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relates to Medicare, Medicaid, CHIP, or the Substance Use Disorders Use Prevention and Treatment Block Grant.

Aetna Better Health of Iowa, Inc. is not yet operational and therefore has no letters of deficiency issued by or corrective actions requested or required by any federal or state regulatory entity within the last five (5) years.

Letters of deficiency issued by or corrective actions requested or required by any federal or state regulatory entity within the last five years relating to Medicare, Medicaid, CHIP, or Substance Use Disorders Use Prevention and Treatment Block Grants can be found in Table T6-3 below, titled Medicare Regulatory Actions and Sanctions, and in Table T6-2 titled "Medicaid Regulatory Actions and Sanctions" set forth in response to Question 2 of Section 3.2.7.4.2 above.

Table T6-3: Medicare Regulatory Actions and Sanctions

Year	Company	Description of Action
2010	Aetna Life Insurance Company	Letter of Deficiency (Notice of Non-Compliance) -Failure to promptly effectuate payments. Closed.
2010	Aetna, Inc.	Letter of Deficiency (Notice of Non-Compliance) -January Secret Shopping Performance, Marketing Surveillance Notice of Noncompliance: Secret Shopping Deficiencies. Closed
2010	Aetna Life Insurance Company	Letter of Deficiency (Notice of Non-Compliance) Customer service representatives (CSRs) continuing to provide inaccurate information to callers about plan premiums. Closed.
2010	Aetna Life Insurance Company	Enrollment Suspension (Intermediate Sanction) -The Centers for Medicare and Medicaid Services ("CMS") imposed intermediate sanctions on Aetna, which consisted of the suspension of all enrollment and marketing activities with respect to Aetna's Medicare Advantage and Standalone Prescription Drug Plan contracts. The effective date of the sanctions was April 21, 2010. Subsequently, CMS provided Aetna with a limited waiver to allow enrollment of members into already contracted group Medicare Advantage and Standalone Prescription Drug Plan Contracts through March 31, 2011. The sanctions were a result of Aetna improperly administrating a transition from an open formulary to a closed formulary for its Part D Medicare members. On June 13, 2011, CMS lifted the intermediate sanctions and Aetna resumed marketing its Medicare Advantage and Standalone Prescription Drug Plan contracts, enrolling beneficiaries with effective dates on and after July 1, 2011.
2010	Aetna, Inc.	Letter of Deficiency (Notice of Non-Compliance) -Marketing Surveillance Notice of Noncompliance: Secret Shopping Deficiencies. Closed
2010	Aetna, Inc.	Letter of Deficiency (Notice of Non-Compliance) -Privacy Breach. Closed.
2010	Aetna, Inc.	Letter of Deficiency (Notice of Non-Compliance) -Benefits and Beneficiary Protections – Disclosure Requirements. Closed.
2010	Aetna, Inc.	CAP (Business Plan) -Use of unqualified sales agents. Business plan submitted to CMS timely.
2010	Aetna, Inc.	Letter of Deficiency (Notice of Non-Compliance) -Distribution of Unapproved Marketing Materials. Closed.

Year	Company	Description of Action
2010	Aetna Life Insurance Company	Letter of Deficiency (Notice of Non-Compliance) - Misuse of Data provided under CMS User Data Agreement. Closed.
2010	Aetna, Inc.	CAP -Production File Submission for Risk Adjustment Data Noncompliance.
2010	Aetna, Inc.	CAP (Business Plan) - Provider Termination Disclosure Requirements.
2010	Aetna, Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to send timely non-renewal notices. Closed.
2010	Aetna Health	Letter of Deficiency (Notice of Non-Compliance) - Translated Marketing Materials. Closed
2010	Aetna Health Inc.	Letter of Deficiency (Notice of Non-Compliance) - Translated Marketing Materials. Closed.
2010	Aetna, Inc.	Letter of Deficiency (Warning Notice) -Failure to successfully submit 4Rx data for at least 99% of its contract year (CY) 2011 CMS-generated enrollments by the deadline.
2010	Aetna Health Inc.	Letter of Deficiency (Warning Letter) - Not implementing appropriate point-of-sale edits on claims for drugs prescribed or dispensed by providers or entities who have been excluded from participation in Federal health care programs by the Department of Health and Human Services Office of the Inspector General (OIG). Closed.
2010	Aetna, Inc.	Letter of Deficiency (Notice of Non-Compliance) -Out of compliance with the requirement that Part D sponsors provide CMS with the drug price information necessary to operate the Medicare Plan Finder (MPF) website. Closed.
2010	Aetna, Inc.	CAP (Business Plan) -Retroactive Changes to Low Income Subsidy Levels.
2011	Coventry Health Care of Florida and Coventry Health Plan of Florida	CAP -FL Office of Insurance Regulation (OIR) reviewed billing information for conversion members and found discrepancies between the amounts billed and amounts approved by OIR.
2011	Coventry Summit Health Plan of Florida	CAP -Financial examination of Medicare bids for 2008. CAP issued because the health plan was not able to produce copies of prescriptions issued by treating providers.
2011	Coventry Health Care of Florida, Coventry Health Plan of Florida and Coventry Summit Health Plan of Florida	CAP -Medicare review of enrollment and disenrollment processes.
2011	Coventry Health Plan of Florida and Coventry Summit Health Care of Florida	Letter of Deficiency (Notice of Non-Compliance) -Medicare newspaper ads' disclaimer language was in grey ink instead of black. Closed.
2011	Coventry Health Plan of Florida and Coventry Health Care of Florida	Letter of Deficiency -Medicare review of organization determinations, Part C appeals and grievances. Closed.
2011	Coventry Health Care of Florida and Coventry Health Plan of Florida	CAP -Office of Insurance Regulation reviewed billing information for conversion members and found discrepancies between the amounts billed and amounts approved by OIR.
2011	Aetna Life Insurance Company	Letter of Deficiency/(Notice) -Notice of a Low Plan Rating (LPR) indicator. Closed.
2011	Aetna Health Inc.	Letter of Deficiency/(Notice) -Notice of a Low Plan Rating (LPR) indicator. Two contracts received notices. Closed.

Year	Company	Description of Action
2011	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to adhere to the CMS requirement that final bid submissions and final actuarial certifications are complete and accurate at the time of submission. Closed.
2011	Aetna Health Inc.	CAP -Failure, as indicated by its most recent low plan (or "star") rating, to meet the administrative and management requirements that apply to Medicare Advantage organizations (MAOs) and stand-alone Medicare Prescription Drug Plan (PDP) sponsors. Seven different contracts received notices to implement a CAP. Closed.
2011	Aetna Health Inc. (Georgia)	CAP -Failure, as indicated by its most recent low plan (or "star") rating, to meet the administrative and management requirements that apply to Medicare Advantage organizations (MAOs) and stand-alone Medicare Prescription Drug Plan (PDP) sponsors. Closed.
2011	Aetna Life Insurance Company	CAP -Failure, as indicated by its most recent low plan (or "star") rating, to meet the administrative and management requirements that apply to Medicare Advantage organizations (MAOs) and stand-alone Medicare Prescription Drug Plan (PDP) sponsors. Two different contracts received notices. Closed.
2011	Aetna Life Insurance Company	Fine (Civil Money Penalty)- $171,240 2010 EOC Inaccuracies. Fine/Penalty paid.
2011	Aetna, Inc.	Letter of Deficiency (Notice of Non-Compliance) -Issuance of inaccurate 2011 Low Income Subsidy (LIS) Riders for the 2011 contract year. Closed.
2011	Aetna Health Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to successfully complete automated true out-of-pocket (TrOOP) balance transfer (TBT) transactions in real-time for 100% of all transactions. Eleven different contract notices received. Closed.
2011	Aetna Life Insurance Company	Letter of Deficiency (Notice of Non-Compliance) -Failure to successfully complete automated true out-of-pocket (TrOOP) balance transfer (TBT) transactions in real-time for 100% of all transactions. Three different contract notices received. Closed.
2011	Aetna Health Inc. (Georgia)	Letter of Deficiency (Notice of Non-Compliance) -Failure to successfully complete automated true out-of-pocket (TrOOP) balance transfer (TBT) transactions in real-time for 100% of all transactions. Closed.
2011	Aetna Inc.	Fine (Civil Money Penalty)- $20,000 for 2011 EOC Inaccuracies. (Contract S5810) Fine/Penalty paid.
2011	Aetna Inc.	CAP -Failure to comply with the Centers for Medicare & Medicaid Services (CMS) requirement to use appropriate compendia as well as peer reviewed medical literature when making coverage determinations regarding medically accepted indications.
2011	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to make a good faith effort to provide written notice of termination of a contracted provider at least 30 days before the termination effective date. Closed.
2012	Aetna Life Insurance Company	Letter of Deficiency (Notice of Non-Compliance) –Related to Part D program guidance regarding payment of local sales tax charges on covered Part D prescription drug transactions. Two different contracts received notices. Closed.
2012	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to make a good faith effort to provide written notice of termination of a contracted provider at least 30 days before the termination effective date. Closed.

Year	Company	Description of Action
2012	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to comply with Medicare requirements concerning timely processing of beneficiary plan enrollments requests. Closed.
2012	Aetna Inc.	CAP (Business Plan) -Failure to Properly Administer Generic Co-pays
2012	Aetna Inc.	Letter of Deficiency (Warning Letter) -Failure to update low-income subsidy (LIS) eligibility records, which resulted in LIS beneficiaries being charged incorrect cost sharing amounts for Part D drugs. Closed.
2012	Aetna Health Inc.	CAP -Failure to Achieve 3 Stars for three consecutive years. Two different contracts received notices.
2012	Aetna Life Insurance Company	CAP -Failure to Achieve 3 Stars for three consecutive years
2012	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to comply with Medicare Marketing Guidelines by neglecting to include physician street addresses and telephone numbers in its 2012 provider directories. Closed.
2012	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to Comply with Prompt Pay Requirements. Closed.
2012	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure To Adhere To Upload Requirements For Scheduled Marketing Events. Closed.
2012	Aetna Health Inc.	CAP -Corrective Action Plan for Failure to Achieve 3 Stars for three consecutive years. Two different contracts received notices.
2012	Aetna Life Insurance Company	CAP -Corrective Action Plan for Failure to Achieve 3 Stars for three consecutive years
2012	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure To Adhere To Upload Requirements For Scheduled Marketing Events
2012	Aetna Inc.	CAP -Areas of non-compliance related to Part D Formulary and Benefits Administration
2012	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to complete the agent/broker compensation requirements timely. Closed.
2012	Aetna Inc.	CAP (Business Plan) -Failure to apply appropriate cost sharing for non-Part D Drugs eligible under the Part D program in clinically relevant situations.
2012	Aetna Life Insurance Company	Letter of Deficiency (Notice of Non-Compliance) -Failure to comply with CMS' requirement that Part D sponsors' final bid submissions must be complete and accurate at the time of submission. Closed.
2012	Aetna Inc.	Letter of Deficiency (Warning Letter) -Failure to meet standard timeframes for Organization Determinations. Closed.
2012	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to provide discount under the Medicare Coverage Gap Discount Program. Closed.
2012	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Sending inappropriate marketing materials. Closed.
2012	Aetna Health Inc. (Pennsylvania)	Letter of Deficiency (Notice of Non-Compliance) -Failure to successfully complete automated true out-of-pocket (TrOOP) balance transfer (TBT) transactions in real-time for 100% of all transactions. Closed.
2012	Aetna Inc.	CAP (Business Plan) -Failure to indicate Prior Authorization on Formularies and Failure to Administer a CMS Approved Formulary.
2012	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Inappropriate content in Prior Authorization (PA) forms used among all Aetna contracts. Closed.

Year	Company	Description of Action
2012	Aetna Health of California, Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Aetna Health Inc. (Pennsylvania)	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Aetna Health Inc. (Georgia)	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Aetna Life Insurance Company	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Aetna Health Inc. (Pennsylvania)	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Aetna Health Inc. (Pennsylvania)	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Aetna Health Inc. (New Jersey)	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Aetna Health Inc. (New York)	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Aetna Health Inc. (Maine)	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Aetna Health Inc. (Pennsylvania)	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Aetna Health Inc. (Pennsylvania)	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Aetna Health Inc. (Texas)	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Aetna Life Insurance Company	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.

Year	Company	Description of Action
2012	Aetna Health Inc. (Pennsylvania)	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Aetna Health Inc. (Florida)	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Aetna Life Insurance Company	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Aetna Health Inc. (Connecticut)	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Aetna Health Inc. (Pennsylvania)	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Aetna Health Inc. (Pennsylvania)	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
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2012	Aetna Life Insurance Company	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Aetna Life Insurance Company	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Aetna Health Inc. (Pennsylvania)	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Aetna Life Insurance Company	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern. Closed.
2012	Coventry Health Care of Florida, Coventry Health Plan of Florida and Coventry Summit Health Plan of Florida	Letter of Deficiency (Notice of Non-Compliance) -Medicare: Improperly imposing step therapy as precondition to provide as Part B drug. Closed.

Year	Company	Description of Action
2012	Coventry Health Care of Florida, Coventry Health Plan of Florida and Coventry Summit Health Plan of Florida	CAP -Medicare: Actuarial compliance 2012 bid discrepancies.
2012	Coventry Health Care of Florida	CAP -Medicare: Failure to adhere to upload requirement for scheduled marketing events.
2012	Coventry Health Care of Florida, Coventry Health Plan of Florida and Coventry Summit Health Plan of Florida	Letter of Deficiency (Notice of Non-Compliance) -Medicare: Failure to comply with marketing requirements concerning accurate description of benefits. LIS letter errors and LEP communication with errors. Closed.
2012	Coventry Health Plan of Florida and Coventry Health Care of Florida	Letter of Deficiency (Notice of Non-Compliance) -Medicare: Troop balance error for 2011. Closed.
2012	Coventry Summit Health Plan of Florida	Letter of Deficiency (Notice of Non-Compliance) -Medicare: Marketing surveillance secret shopper deficiencies. Closed.
2012	Coventry Health Care, Inc.	Settlement -$3,000,000 Investigation into the operational process for confirming Medicare eligibility for Workers' Compensation set-aside product.
2013	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Dissemination of Inaccurate Plan Information to State of Maine EGWP Members. Closed.
2013	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to provide discounts under the Medicare Coverage Gap Discount Program. Closed
2013	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Issuance of inaccurate Annual Notice of Change/Evidence of Coverage (ANOC/EOC) documents to Medicare members. Closed
2013	Aetna Health Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to Adhere to the January 8, 2013, HPMS Memo Regarding ANOC/EOC Accuracy Assessment. Closed.
2013	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to provide accurate information in Contract Year (CY) 2013 Summary of Benefits (SB) document to beneficiaries. Closed.
2013	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to provide accurate information in Contract Year (CY) 2013 Summary of Benefits (SB) document to beneficiaries. Closed.
2013	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to adhere to agent/broker compensation rules. Closed.
2013	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to provide accurate information in Coventry CY2013 Summary of Benefits. Closed.
2013	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to adhere to agent/broker compensation rules regarding renewal commissions and failing to use the calendar year as a basis for compensation. Closed.
2013	Aetna Inc.	CAP -Aetna – Immediate Corrective Action Required (ICAR) for two deficiencies from the 2013 CMS Performance Audit
2013	Aetna Health Inc. (Pennsylvania)	CAP (Business Plan) -Failure to transfer 100% of TBT transactions in real-time and successfully transfer 100% of beneficiary benefit balances within 30 days of the CMS TrOOP facilitator having sent the data to Aetna.

Year	Company	Description of Action
2013	Aetna Health Inc. (Pennsylvania)	Letter of Deficiency (Warning Letter) -Failure to transfer 100% of TBT transactions in real-time and to successfully transfer 100% of beneficiary benefit balances within 30 days of the CMS TrOOP facilitator having sent the data to Aetna. Closed.
2013	Aetna Life Insurance Company	Letter of Deficiency (Notice of Non-Compliance) -Failure to transfer 100% of TBT transactions in real-time and to successfully transfer 100% of beneficiary benefit balances within 30 days of the CMS TrOOP facilitator having sent data to Aetna. Three different contracts received notices. Closed.
2013	Aetna Health Inc. (Florida)	Letter of Deficiency (Notice of Non-Compliance) -Failure to transfer 100% of TBT transactions in real-time, and failed to successfully transfer 100% of beneficiary benefit balances within 30 days of the CMS TrOOP facilitator having sent the data to Aetna. Closed.
2013	Aetna Health Inc. (Pennsylvania)	Letter of Deficiency (Notice of Non-Compliance) -Failure to transfer 100% of TBT transactions in real-time, and failed to successfully transfer 100% of beneficiary benefit balances within 30 days of the CMS TrOOP facilitator having sent the data to Aetna. Closed.
2013	Aetna Life Insurance Company	Letter of Deficiency (Notice of Non-Compliance) –Non-compliance with survey requirements regarding Cialis. Closed.
2013	Aetna Life Insurance Company	Letter of Deficiency (Notice of Non-Compliance) –Non-compliance with survey requirements regarding Cialis. Closed.
2013	Aetna Health Inc. (Texas)	Letter of Deficiency (Notice of Non-Compliance) -Out of compliance with the survey requirements regarding Cialis. Closed.
2013	First Health Life & Health Insurance Company	Letter of Deficiency (Notice of Non-Compliance) -Failure to comply with Medicare Part D requirements regarding coverage of Cialis. Closed.
2013	Coventry Summit Health Plan of Florida	Letter of Deficiency (Notice of Non-Compliance) -Failure to comply with Medicare Part D requirements regarding coverage of Cialis. Closed.
2013	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to properly administer the Part D Benefit plan. Closed.
2013	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to accurately process coordination of benefits for prescription drugs, and for failing to assess appropriate co-payments at point of sale. Closed.
2013	Coventry	CAP -Coventry – Immediate Corrective Action Required (ICAR) for three deficiencies from the 2013 CMS Performance Audit.
2013	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to process Part B vs. Part D claims correctly. Closed.
2013	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to conduct outbound enrollment and verification calls to new members. Closed.
2013	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to properly cancel enrollments for members who opted out of Part D auto facilitated enrollment. Closed.
2013	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to provide accurate information in the EOC for Special Need Plans. Closed.
2013	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to Correctly Process Claims for Hydrochlorothiazide. Closed.
2013	Aetna Health of Utah Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit a complete and accurate final bid at the time of submission. Closed.

Year	Company	Description of Action
2013	Coventry Health Care of Florida, Coventry Health Plan of Florida and Coventry Summit Health Plan of Florida	Letter of Deficiency (Notice of Non-Compliance) -ANOC/EOCs failure to adhere to the accuracy assessment. Closed.
2013	Coventry Summit Health Plan of Florida	Letter of Deficiency (Notice of Non-Compliance) -Summary of Benefits were inaccurate. Closed.
2013	Coventry Health Care of Florida, Coventry Health Plan of Florida and Coventry Summit Health Plan of Florida	Letter of Deficiency (Technical Assistance Letter) -Medicare: Marketing surveillance. Closed.
2013	Coventry Health Care of Florida, Coventry Health Plan of Florida and Coventry Summit Health Plan of Florida	Letter of Deficiency (Notice of Non-Compliance) -Medicare: Inappropriate claims rejection of controlled substance at point of sale. Closed.
2013	Coventry Health Plan of Florida	Letter of Deficiency (Notice of Non-Compliance) -ANOC/EOCs were inaccurate. Closed.
2013	Coventry Health Plan of Florida and Coventry Summit Health Care of Florida	Letter of Deficiency (Notice of Non-Compliance) -ANOC/EOCs failure to adhere to the Accuracy Assessment. Closed.
2013	Coventry Summit Health Plan of Florida	Letter of Deficiency (Notice of Non-Compliance) -SBs were inaccurate. Closed.
2013	Coventry Health Care of Florida, Coventry Health Plan of Florida and Coventry Summit Health Plan of Florida	Letter of Deficiency (Notice of Non-Compliance) -Medicare: Notice of non-compliance incorrect. Broker compensation payment. Closed.
2013	Coventry Health Care of Florida	Letter of Deficiency (Notice of Non-Compliance) -Case file submission untimely. Closed.
2013	Coventry Health Care of Florida, Coventry Health Plan of Florida and Coventry Summit Health Plan of Florida	Letter of Deficiency (Notice of Non-Compliance) -Medicare: Improper administration of Part D benefit plan. Ventolin and “time out” rejections at point of sale resulted in denials. Closed.
2014	Aetna Inc.	CAP (Business Plan) -Long Term Care Pharmacy Reimbursement
2014	Aetna Health Inc. (Connecticut)	Letter of Deficiency (Warning Letter) -Failing to properly implement the required transition policy. Closed.
2014	Aetna Health Inc. (Texas) Aetna Health Inc. (Georgia) Aetna Health Inc. (Pennsylvania)	CAP -CMS Low Star Rating
2014	Aetna Inc.	Fine (Civil Money Penalty) -$407,800 Medicare Advantage-Prescription Drug and Prescription Drug Plan – Coventry. Fine paid.
2014	Aetna Inc.	Fine (Civil Money Penalty) -$101,500 Medicare Advantage-Prescription Drug and Prescription Drug Plan – Aetna. Fine paid.
2014	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Issuance of inaccurate Annual Notice of Change/Evidence of Coverage (ANOC/EOC) documents to Medicare members for the Contract Year 2014. Closed.
2014	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Issuance of inaccurate Annual Notice of Change/Evidence of Coverage (ANOC/EOC) documents to Medicare members for the Contract Year 2014. Closed

Year	Company	Description of Action
2014	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to Conduct Outbound Enrollment Verification and Verification Calls to New Members. Closed
2014	Aetna Inc.	CAP -Issuance of inaccurate Annual Notice of Change/Evidence of Coverage (ANOC/EOC) documents to Medicare members for the Contract Year 2014.
2014	Coventry Health Care Of Missouri, Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit a MIPPA compliant State Medicaid Agency Contract by the submission deadline. EDT. Closed.
2014	Coventry Health Plan of Florida, Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit a MIPPA compliant State Medicaid Agency Contract by the submission deadline. EDT. Closed
2014	HealthAmerica Pennsylvania, Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to submit a MIPPA compliant State Medicaid Agency Contract by the submission deadline. EDT. Closed
2014	Aetna Inc.	CAP -Issuance of inaccurate Annual Notice of Change/Evidence of Coverage (ANOC/EOC) documents to Medicare members for the Contract Year 2014.
2014	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to Process Non-Contracted Provider Claims Correctly. Closed
2014	Aetna Life Insurance Company	Fine -$8,000.00 for failure to revise required fraud warning on three Medicare Supplement applications and 264 policies which were sold using non-compliant applications. Fine paid.
2014	Coventry Health and Life Company	Letter of Deficiency (Warning Letter) -Failing to properly implement the required transition policy. Closed.
2014	Coventry Summit Health Plan, Inc.	Letter of Deficiency (Warning Letter) -Failing to properly implement the required transition policy. Closed.
2014	First Health Life and Health Insurance Company	Letter of Deficiency (Warning Letter) -Failing to properly implement the required transition policy. Closed.
2014	Aetna, Inc.	Letter of Deficiency (Notice of Non-Compliance) -Aetna – Failure to properly administer the Part D benefit plan. Closed.
2014	Aetna Life Insurance Company, Aetna Health Inc. (Texas)	Letter of Deficiency (Warning Letter) -Failure to Comply with Medicare Part D Requirements Related to the Coverage of Cialis. Closed.
2014	Aetna Life Insurance Company	Letter of Deficiency (Notice of Non-Compliance) -Failure to Comply with Medicare Part D Requirements Related to the Coverage of Cialis. Closed.
2014	Aetna, Inc.	Letter of Deficiency (Notice of Non-Compliance) -For requesting a plan correction of a bid after submission, failing one or more bid requirements or submitting an incomplete bid. Closed.
2015	Aetna Inc.	Letter of Deficiency (Notice of Non-Compliance) -For requesting a plan correction of a bid after submission, failing one or more bid requirements or submitting an incomplete bid. Closed.
2015	Aetna Inc.	CAP -Regarding our compliance with the Part D “Any Willing Provider” (AWP) requirements
2015	Aetna, Inc.	CAP -Failure to Comply with CMS CY2015 Bid Instructions
2015	Aetna, Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to maintain accurate information in HPMS. Closed.
2015	Aetna, Inc.	Letter of Deficiency (Notice of Non-Compliance) -Failure to maintain adequate Retail Pharmacy Access. Closed

Year	Company	Description of Action
2015	Coventry Health Care of Virginia, Inc.	CAP (Business Plan) -Failure to submit accurate information in an application for a 2015 Part D Contract
2015	Coventry Health Plan of Florida, Inc. (H1013)	Letter of Deficiency (Notice of Non-Compliance) -Failure to Submit State Medicaid Agency Contract (SMAC) Attestations timely. Closed.
2015	Aetna Better Health of Ohio	Letter of Deficiency (Notice of Noncompliance) -For failure to timely mail all required 2015 marketing materials to members passively enrolled for both Medicare and Medicaid effective 1/1/2015. The regulators replaced NONC with a revised NONC. The revised NONC will impact plan's CMS past performance scorecard for 2015 and 2016. The revised NONC is considered by CMS both a Part C and a Part D issue with beneficiary impact.
2015	Aetna, Inc.	Fine (Civil Money Penalty) -$1,000,000 involving Medicare Advantage-Prescription Drug (MA-PD) and Prescription Drug Plan (PDP). Non-network retail pharmacies erroneously identified as in-network. Involves multiple contracts.

3.2.7.4.3 Contract Description

3.2.7.4.3 Description of all contracts and projects currently undertaken by the bidder. This shall include all contracts that have not expired, have not been completed, or have not been terminated. Descriptions of similar services (above) do not need to be repeated again in this section. If a Bidder does not have current contracts and projects, it may include those of its parent company if it includes a parent guarantee with its proposal.

Please refer to Table T6-1 "Publicly-Funded Managed Care Contracts for Medicaid, CHIP and other low-income individuals" in response to Section 3.2.7.4.2, Question 1 above, which contains a description of all contracts and projects currently undertaken by Aetna Medicaid.

3.2.7.5 Select Attachments Not Included in Page Count

3.2.7.5 Select Attachments Not Included in Page Count Some reports and attachments may be included behind Tab 6 and will not count toward the 1000 page limit. These include:

• EQRO Reports referenced in Attachment 5: Technical Proposal Response Template Section 14 question 5.

• Implementation Plan referenced in Attachment 1: Scope of Work Section 2.14

• HEDIS Scores referenced in Attachment 1: Scope of Work Section 10.1

• Provider Contract Agreement Templates referenced in Attachment 1: Scope of Work Section 6.1.2.

Please find the following documents as indicated below:

- EQRO Reports referenced in Attachment 5: Section 14, Question 5 – Appendix T
- Implementation Plan referenced in Attachment 1: Scope of Work Section 2.14 – Appendix U
- HEDIS Scores referenced in Attachment 1: Scope of Work Section 10.1 – Appendix V
- Provider Contract Agreement Templates referenced in Attachment 1: Scope of Work Section 6.1.2 – Appendix W

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aetna®

AETNA BETTER HEALTH® OF IOWA

Exhibit A: Release of Information Form

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Exhibit A: Release of Information

(Return this completed form behind Tab 6 of the Bid Proposal.)

Aetna Better Health of Iowa Inc. (name of bidder) hereby authorizes any person or entity, public or private, having any information concerning the bidder's background, including but not limited to its performance history regarding its prior rendering of services similar to those detailed in this RFP, to release such information to the Agency.

The bidder acknowledges that it may not agree with the information and opinions given by such person or entity in response to a reference request. The bidder acknowledges that the information and opinions given by such person or entity may hurt its chances to receive contract awards from the Agency or may otherwise hurt its reputation or operations. The bidder is willing to take that risk. The bidder agrees to release all persons, entities, the Agency, and the State of Iowa from any liability whatsoever that may be incurred in releasing this information or using this information.

Aetna Better Health of Iowa Inc.
Printed Name of Bidder Organization

Signature of Authorized Representative

5/18/15
Date

Pamela Sedmak
Printed Name

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AETNA BETTER HEALTH® OF IOWA

Exhibit B: Primary Bidder Detail and Certification Form

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Exhibit B: Primary Bidder Detail Form & Certification

(Return this completed form behind Tab 6 of the Proposal. If a section does not apply, label it "not applicable".)

Primary Contact Information (individual who can address issues re: this Bid Proposal)	
Name:	Laurie Munn
Address:	4500 E. Cotton Center Blvd. Phoenix, AZ 85040
Tel:	602-659-2072
Fax:	1-860-273-1658
E-mail:	MunnL@aetna.com

Primary Bidder Detail	
Business Legal Name ("Bidder"):	Aetna Better Health of Iowa Inc.
"Doing Business As" names, assumed names, or other operating names:	Aetna Better Health or Aetna Better Health of Iowa
NAIC Number:	Not yet issued
Parent Corporation, if any:	Aetna Health Holdings, LLC
Form of Business Entity (i.e., corp., partnership, LLC, etc.):	Corporation
State of Incorporation/organization:	Iowa
Primary Address:	151 Farmington Ave, Hartford, CT 06156-001
Tel:	1-800-872-3862
Fax:	1-860-273-1658
Local Address (if any):	4320 NW 114th Street, Urbandale, IA 50322
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	4500 E. Cotton Center, Phoenix, AZ 85040
Number of Employees:	None
Number of Years in Business:	Incorporated on 4/24/2015
Primary Focus of Business:	Medicaid Managed Care
Federal Tax ID:	47-3850677
Bidder's Accounting Firm:	Ernst & Young
If Bidder is currently registered to do business in Iowa, provide the Date of Registration:	4/24/2015
Do you plan on using subcontractors if awarded this Contract? {If "YES," submit a Subcontractor Disclosure Form for each proposed subcontractor.}	Yes

Request for Confidential Treatment (See Section 3.1)		
Location in Bid (Tab/Page)	**Statutory Basis for Confidentiality**	**Description/Explanation**
See Attached		

Request for Confidential Treatment (See Section 3.1)		
Location in Bid (Tab/Page)	**Statutory Basis for Confidentiality**	**Description/Explanation**
Tab 1, Transmittal Letter, Figure TL-5, Page 12	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Describes Aetna's face to face outreach strategy and relationships with key providers.
Tab 3, Section 1, Figure 1-5, Page 42	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Describes Aetna's face to face outreach strategy and relationships with key providers.
Tab 3, Section 2.2, Question 1; Table 2-2 Proposed subcontractors and parent companies, Page 49	Iowa Code § 22.7(3) Trade Secret	Indicates proposed subcontractors
Tab 3, Section 2.2, Question 1; Figure 2-1: Organizational chart of proposed subcontractors, Page 50	Iowa Code § 22.7(3) Trade Secret	Indicates organizational oversight of proposed subcontractors
Tab 3, Section 2.9, Question 2; Table 2-6, Pages 65-122	Iowa Code § 22.7(3) Trade Secret	Job Descriptions for positions in our Staffing Plan
Tab 3, Section 2.11, Question 1, Figure 2-9, Page 141	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Describes Aetna's face to face outreach strategy and relationships with key providers.
Tab 3, Section 2.14, Question 1; Table 2-7, Page 145	Iowa Code § 22.7(3) Trade Secret	Provides specifics of proprietary and strategic implementation plan
Tab 3, Section 3, Figure 3-1, Page 159	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Describes Aetna's face to face outreach strategy and relationships with key providers.
Tab 3, Section 3, Figure 3-3, Page 183	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Describes Aetna's EPSDT HEDIS Performance
Tab 3, Section 3.2.14, **ENTIRE** response to **Question 1**, Pages 217-224	Iowa Code § 22.7(3) Trade Secret	Describes our proposed Value Added Services to Members
Tab 3, Section 3.2.14, **ENTIRE** response to **Question 2**, Page 225	Iowa Code § 22.7(3) Trade Secret	Describes our proposed Value Added Services to Members
Tab 3, Section 6.1, General Provisions, Figure 6-2, Page 319	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Describes Aetna's face to face outreach strategy and relationships with key providers.
Tab 3, Section 6.1, General	Iowa Code § 22.7(3) Trade Secret	Describes Aetna's face to face

(*Continuing from Page 19*)

Request for Confidential Treatment (See Section 3.1)		
Location in Bid (Tab/Page)	**Statutory Basis for Confidentiality**	**Description/Explanation**
Provisions, Page 321	Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	outreach strategy and relationships with key providers.
Tab 3, Section 6.1, General Provisions, Page 322	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Describes Aetna's face to face outreach strategy and relationships with key providers.
Tab 3, Section 6.1, Question 2, Table 6-1, Page 326	Iowa Code § 22.7(3) Trade Secret	Describes Aetna's strategies to solve for network deficiencies.
Tab 3, Section 6.1.2, Question 4, Page 330	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Describes Aetna's value-based purchasing strategy
Tab 3, Section 8.1, Marketing, Table 8-1, Pages 395 and 396	Iowa Code § 22.7(3) Trade Secret	Describes Aetna's face to face outreach strategy and relationships with key providers.
Tab 3, Section 8.1, Question 1, Table 8-2, Page 397	Iowa Code § 22.7(3) Trade Secret	Describes Aetna's marketing and outreach initiatives.
Tab 3, Section 8.1, Question 1, Page 397-398	Iowa Code § 22.7(3) Trade Secret	Describes Aetna's marketing and outreach plan.
Tab 3, Section 8.5, Question 1, Pages 420 - 422	Iowa Code § 22.7(3) Trade Secret	Describes functionality of Aetna Medicaid's mobile application.
Tab 3, Section 8.8, Question 1 Figure 8-15, Page 433	Iowa Code § 22.7(3) Trade Secret	Describes design and functionality of Aetna Medicaid's cost calculator.
Tab 3, Section 9.1.1, Question 4, Page 476	Iowa Code § 22.7(3) Trade Secret	Portions of this response provides information concerning our proposed Value Added Services
Tab 3, Section 9.1.7, Question 2, Page 506	Iowa Code § 22.7(3) Trade Secret	Portions of this response provide information concerning our proposed Value Added Services
Tab 3, Section 10,Table 10-4, Pages 535-536	Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Describes Aetna's HEDIS Performance
Tab 3, Section 10, Table 10-5, Page 537	Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Describes Aetna's CAHPS Performance
Tab 3, Section 10, Table 10-7, Page 543	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Describes Aetna's strategies for contributing to the Healthiest State Initiative
Tab 3, Section 10, Table 10-8, Pages 543-544	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to	Describes Aetna's strategies for contributing to the MHDS

(*Continuing from Page 19*) Page **21** of **49**

Request for Confidential Treatment (See Section 3.1)		
Location in Bid (Tab/Page)	**Statutory Basis for Confidentiality**	**Description/Explanation**
	Governmental Entities Advantaging Competitors	Redesign
Tab 3, Section 10.2, Question 3, Page 544-545	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Describes Aetna's value-based purchasing strategy
Tab 3, Section 10.3 Question 1, Pages 548-554 (**entire response to question 1**)	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Describes Aetna's proposed provider incentives, all components of our Value-Based Purchasing strategy, provider selection criteria for VBP.
Tab 3, Section 10.3, Question 2, Pages 555-562 (**entire response to question 2**)	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Describes Aetna's proposed member incentives.
Tab 3, Section 11.1, Question 2.b, Page 590	Iowa Code § 22.7(3) Trade Secret	A portion of this response provides information concerning our Provider incentive program
Tab 3, Section 11.1, Question 7, Page 603	Iowa Code § 22.7(3) Trade Secret	A portion of this response provides information concerning our proposed Value Added Services
Tab 3, Section 11.1, Question 8, Page 604	Iowa Code § 22.7(3) Trade Secret	A portion of this response provides information concerning our proposed Value Added Services
Tab 3, Section 11.1, Question 8, Page 605	Iowa Code § 22.7(3) Trade Secret	Portions of this response provide information concerning our proposed Value Added Services
Tab 3, Section 11.1, Question 8, Page 606	Iowa Code § 22.7(3) Trade Secret	Portions of this response provide information concerning our proposed Value Added Services
Tab 3, Section 11, Table 11-4, Page 607 - 608	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Describes Aetna's HEDIS Performance
Tab 3, Section 11, Table 11-5, Page 608	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Describes Aetna's CAHPs Performance
Tab 3, Section 12.1, Figure 12-1, Page 626	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Demonstrates Aetna's organizational structure for our Fraud, Waste and Abuse prevention team.

(*Continuing from Page 19*) Page **22** of **49**

Request for Confidential Treatment (See Section 3.1)		
Location in Bid (Tab/Page)	**Statutory Basis for Confidentiality**	**Description/Explanation**
Tab 3, Section 13.1, Question 1, Page 641	Iowa Code § 22.7(3) Trade Secret	A portion of this response provides information concerning our proposed Value Added Services
Tab 3, Section 13, Figure 13-1, Pages 643-644	Iowa Code § 22.7(3) Trade Secret	Describes Aetna's IS infrastructure
Tab 3, Section 13, Figure 13-2, Page 645	Iowa Code § 22.7(3) Trade Secret	Describes Aetna's IS Integrated systems.
Tab 3, Section 13, Table 13-1, Pages 649-650	Iowa Code § 22.7(3) Trade Secret	Describes Aetna's mobile app
Tab 3, Section 13, Figure 13-4, Page 652	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Describes Aetna's data storage locations
Tab 3, Section 13.1, Question 5, Page 657	Iowa Code § 22.7(3) Trade Secret	Portions of this response provide information about our proposed staffing plan
Tab 3, Section 13.1, Question 5, Page 658	Iowa Code § 22.7(3) Trade Secret	Portions of this response provide information about our proposed staffing plan
Tab 3, Section 13, Figure 13-15, Page 692	Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Describes Aetna's encounter data submission accuracy rate by plan and month
Tab 3, Section 13.7, Question 1, Page 706	Iowa Code § 22.7(3) Trade Secret	A portion of this response provides information concerning our proposed Value Added Services
Tab 3, Section 13.7, Question 1, Figure 13-20: Sample mobile app, Page 707	Iowa Code § 22.7(3) Trade Secret	A portion of this response provides information concerning our proposed Value Added Services
Tab 3, Section 14, Figure 14-2, Page 727	Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Describes Aetna's custom LTSS Triage Report
Tab 3, Section 14, Figure 14-3, Page 728	Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Describes Aetna's custom UM Report
Tab 4, Section 3.2.5.1.5, Figure T4-2, Page 754	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Demonstrates org chart of Aetna Better Health parent and affiliates.
Tab 4, Section 3.2.5.1.5, Table T4-3, Page 755	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities	Demonstrates Aetna's relationship and experience with subcontractors.

(*Continuing from Page 19*) Page **23** of **49**

Request for Confidential Treatment (See Section 3.1)		
Location in Bid (Tab/Page)	**Statutory Basis for Confidentiality**	**Description/Explanation**
	Advantaging Competitors	
Tab 4, Section 3.2.5.2.1, Figure T4-3, Page 756	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Demonstrates Aetna's overall operational org chart.
Tab 4, Section 3.2.5.2.1, Table T4-4, Pages 757 - 758	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Demonstrates Aetna's staffing plan.
Tab 4, Section 3.2.5.2.1, Figure T4-4, Page 759	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Demonstrates Aetna's leadership organizational structure.
Tab 4, Section 3.2.5.2.1, Figure T4-5, Page 760	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Demonstrates Aetna's Medical Management organizational structure.
Tab 4, Section 3.2.5.2.1, Figure T4-6, Page 761	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Demonstrates Aetna's Operations organizational structure.
Tab 4, Section 3.2.5.2.2, Table T4-5, Page 763	Iowa Code § 22.7(3) Trade Secret Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Demonstrates names and credentials of Aetna's board of directors.
Ownership Disclosure, Tab 5, Appendix B, page 780-781, Pages 785-786	Iowa Code § 22.7(6) Reports to Governmental Entities Advantaging Competitors	Discloses Executive Personal Information (DOB)
Disaster Recovery Plan, Tab 5, Appendix Q, Pages 948-979	Iowa Code § 22.7(3) Trade Secret	Provides specifics of proprietary and strategic Disaster Recovery plan
Encounter Claims Plan, Tab 5, Appendix R. Pages 784-786	Iowa Code § 22.7(3) Trade Secret	Provides specifics of proprietary and strategic Encounter Claims plan
Implementation Plan, Tab 6, Appendix U, pages 1619-1638	Iowa Code § 22.7(3) Trade Secret	Provides specifics of proprietary and strategic implementation plan

(*Continuing from Page 19*)

BID PROPOSAL CERTIFICATION

By signing below, Bidder certifies that:

1. Reserved;
2. Bidder accepts all capitation rates established by the Agency via the Agency's actuary.
3. Bidder has reviewed the Additional Certifications, which are incorporated herein by reference, and by signing below represents that Bidder agrees to be bound by the obligations included therein.
4. Bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;
5. Reserved;
6. Bidder has received any amendments to this RFP issued by the Agency;
7. Bidder either is currently registered to do business in Iowa or agrees to register if Bidder is awarded a Contract pursuant to this RFP;
8. The person signing this Bid Proposal certifies that he/she is the person in the Bidder's organization responsible for, or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive agreements outlined above;
9. Bidder specifically stipulates that the Bid Proposal is predicated upon the acceptance of all terms and conditions stated in the RFP and the Sample Contract without change.
10. Bidder certifies that the Bidder organization has sufficient personnel resources available to provide all services proposed by the Bid Proposal, and such resources will be available on the date the RFP states services are to begin. Bidder guarantees personnel proposed to provide services will be the personnel providing the services unless prior approval is received from the Agency to substitute staff;
11. Bidder certifies that if the Bidder is awarded the contract and plans to utilize subcontractors at any point to perform any obligations under the contract, the Bidder will (1) notify the Agency in writing prior to use of the subcontractor, and (2) apply all restrictions, obligations, and responsibilities of the resulting contract between the Agency and contractor to the subcontractors through a subcontract. The contractor will remain responsible for all Deliverables provided under this contract.
12. Bidder guarantees the availability of the services offered and that all Bid Proposal terms, including price, will remain firm until a contract has been executed for the services contemplated by this RFP or one year from the issuance of this RFP, whichever is earlier; and,
13. Bidder certifies it is either a) registered or will become registered with the Iowa Department of Revenue to collect and remit Iowa sales and use taxes as required by Iowa Code chapter 423; or b) not a "retailer" of a "retailer maintaining a place of business in this state" as those terms are defined in Iowa Code subsections 423.1(42) & (43). The Bidder also acknowledges that the Agency may declare the bid void if the above certification is false. Bidders may register with the Department of Revenue online at: http://www.state.ia.us/tax/business/business.html.

By signing below, I certify that I have the authority to bind the Bidder to the specific terms, conditions and technical specifications required in the Agency's Request for Proposals (RFP) and offered in the Bidder's Proposal. I understand that by submitting this Bid Proposal, the Bidder agrees to provide services described herein which meet or exceed the specifications of the Agency's RFP unless noted in the Bid Proposal and at the prices quoted by the Bidder. I certify that the contents of the Bid Proposal are true and accurate and that the Bidder has not made any knowingly false statements in the Bid Proposal.

Signature:	
Printed Name/Title:	Pamela Sedmak, SVP, President and Chief Executive Officer Aetna Medicaid
Date:	5/18/15

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AETNA BETTER HEALTH® OF IOWA

3.2.7.3 Resumes

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Janet Grant
Contract Administrator/CEO

EMPLOYMENT HISTORY

Interim CEO, Aetna Better Health of Iowa, 2015 – Present

Aetna

Regional Vice President, Great Plains Region, 2013 – Present

- Leads Aetna Medicaid's Great Plains Region, which operates Medicaid plans in Nebraska, Missouri and Texas. Accountable for profit and loss, growth, and operational effectiveness, including quality, compliance and state contract requirements. Also is responsible for new business growth and expansion across the region as well as key stakeholder relationships and community partners.

CareSource Management Group, Dayton, OH

Executive Vice President, External Affairs and Corporate Compliance Officer, 2002 – 2013

- Senior executive for a high growth national leader in Medicaid managed care, with nearly $4B annual revenue and approximately 950,000 members. Responsible for health policy and advocacy, corporate compliance and strategic stakeholder relationships with regulators, legislators, consumer advocates, industry and provider trade associations. Serve as the Corporate Compliance Officer. Experience includes corporate oversight and accountability for multi-state Medicaid plans. Deep experience with business development, strategic planning, and network development to support expansions/state implementations for both full risk and administrative services plans.
  - Leadership role in the establishment and administration of a multi-state strategic alliance with Humana that has resulted in successful contract awards in three states in 18 months
  - Successfully led business development strategy which has resulted in Medicaid bid contracts awarded at a 90% success rate across four states with timely implementations
  - Led the business development strategy that resulted in CareSource being awarded participation in a financial alignment demonstration for dual eligibles to be launched in 2014
  - Provided key political advocacy leadership with results that include statewide expansion of Ohio Medicaid managed care, inclusion of ABD adults and children, and dual eligibles in managed care and pharmacy carve-in
  - Led the successful acquisition of Michigan Medicaid plan consisting of 55,000 lives, transitioned from an administrative services contract to a full-risk plan; responsible for leading competitive bidding process, purchase negotiations, and regulatory strategy which resulted in the approval of acquisition
  - Responsible for application, due diligence process and closing of a $9 million loan guaranteed by HRSA to successfully recapitalize Michigan plan contracted for administrative services
  - Secured contract and directed implementation for comprehensive administrative plan management; key leadership role in appointment of organization as co-rehabilitator of the plan and led and executed turn around initiatives resulting in plan emergence from rehabilitation
  - Successful implementation and management of a Corporate Integrity Agreement owning the relationship with the OIG and the contracted independent review organization

- Developed and launched Montgomery County Care, a local ambulatory coverage program for uninsured adults funded by county human service levy
- Led successful CMS application process for participation as Medicare Advantage Special Needs Plans in Ohio and Michigan

Wright State University School of Medicine, Dayton, Ohio

Senior Consultant, Health Systems Management, 2000 – 2002

- Leadership role within a new division of the School of Medicine with a mission to promote the development of management, health economics, leadership and population based skills for physicians and health care providers.
  - Launched new medical school division as co-founder with the endowed chair physician leader
  - Led project to design and analyze the feasibility of a pilot Medicaid expansion program including development of economic cost and funding models
  - Served as project manager for grant applications and coordinated funded research
  - Developed and marketed a health care consulting practice
  - Planned and executed physician CME conferences with national and international participants and a visiting lectureship series

Kettering Medical Center Network, Kettering, Ohio

Leader, Senior Service Line/Strategic Business Unit and Social Services Department, 1993 – 2000

- Developed health system service line targeted to the senior population, one of seven designated service lines. Coordinated all service line activities across four hospital system including strategic planning, market research, advertising, new program development, continuum of care coordination, medical staff recruitment and integration, medical education, quality improvement, and community relationships. In addition, directed overall social service departmental operations; responsible for meeting patient and organizational needs for social work interventions and discharge planning in the four network acute care hospitals.
  - Developed and executed new business plans including KMC Senior Health Center, Geriatric Care Physician Services, Kettering Osteoporosis Center, and an inpatient rehabilitation unit
  - Served as organizational liaison for joint venture with a national long term care provider for two skilled nursing facilities
  - Led request for proposal and contracting process for host and purchased service relationship with a long term acute care hospital
  - Coordinated implementation of Medicare HMO contracts; responsible for marketing partnerships, community education and case management support
  - Designed and managed Years Ahead senior membership program growing to 58,000 members

EDUCATION

Masters of Business Administration

Wright State University, Dayton, Ohio

Bachelor of Social Work

Minnesota State University, Moorhead, Minnesota

BACKGROUND (CERTIFICATIONS, LICENSES, ETC.)

Committee Appointments

- Ohio Medical Advisory Committee, appointed by the Ohio Director of Job and Family Services
- Ohio Unified Long Term Care System Work Group, appointed by Governor John Kasich
- Ohio Coverage and Quality Council, appointed by Governor Ted Strickland
- Ohio Care Management Working Group, appointed by the Ohio Senate President

Professional Societies

- Ohio Association of Health Plans, Board, Chair of Medicaid and Compensation Committees
- Leadership Dayton, Dayton Chamber of Commerce
- Sigma Iota Epsilon, honorary management fraternity
- Beta Gamma Sigma, honorary business fraternity

Community Service

- Area Agency on Aging PSA-2, Board
- Senior Resource Connection, Board, Treasurer

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Eileen Shaw
Chief Operating Officer

EMPLOYMENT HISTORY

Director of Implementation, 2008 – Present

Aetna Inc.

- Provides day-to-day functional leadership to the Implementation Team to ensure a successful transition of members to the health care plan
- Responsible for providing operational direction for design, development, build-out (including attaining financial performance and viability targets) and successful implementation of new health plan operations
- Represent the organization to the Medicaid agency, other related agencies, regulatory agencies, advocacy groups, community organizations, candidates for employment, Medicaid or other members and the public
- Leads implementation activities in the following areas:
  - Care Management
  - Disease Management
  - Medical Management (UM/QM)
  - Operations (Claims/ Call Center)
  - Member Services/ Member Communication
  - Provider Relations/ Network Management
  - Information Technology (including corporate IT and State MMIS, enrollment brokers and fiscal agent vendors)
  - Hiring and retention of employees

Corporate Director, Pathways to Chronic Care, 2007-2008

Aetna Inc.

- Identified, analyzed, planned, developed, organized, implemented and evaluated functions of the Pathways to Chronic Care programs for Aetna Better Health and affiliate organizations
- Responsible for the support of leadership executives in the performance of their duties and serve as a backup in their absence including, but not limited to:
  - New product development
  - Contract management and analysis
  - RFP response direction
  - Project management
  - Implementation of new business, products and systems initiatives, strategic planning and implementation of strategic goals and objectives for medical management
- Designed, modified, and proposed operation systems and processes to most effectively manage quality, utilization and risk in clinical elements of the total care management program
- Provided oversight and support to all new Pathways to Chronic Care implementations

Director of Care Management, 2006-2007

Aetna Inc.

- Identified, analyzed, planned, developed, organized, implemented and evaluated functions within the Medical Management Department for Aetna Better Health and its health plan affiliates for the following areas:
  - Care Coordination
  - Care Management
  - Perinatal Management
  - Disease Management
- Provided oversight to the centralized Disease Management department, along with all Care Management activities
- Managed training functions for all health plans related to Care Management, Care Coordination and Disease Management
- Developed budget requirements for all functional areas including project budgets for implementation of new lines of business

Director of Utilization Management, 2005-2007

Aetna

- Assisted health plans in the development and monitoring of the annual utilization management plan and annual evaluation of the utilization management activities
- Performed annual audits of the health plans' utilization management plans
- Monitored all health plan local medical trends, analyze patterns that impact the effort to effectively manage utilization and quality of medical services and report these through the 30-60-90 process
- Developed project budget requirements for affiliated health plans and for medical claims review
- Worked with utilization management department at each health plan to develop innovative approaches to improve cost effectiveness and reduce administrative expenses
- Ensured that all health plans have up-to-date utilization management policies, desktops and toolkits based on Schaller Anderson standards

EDUCATION

A.A.S. – Nursing

Monroe Community College, Rochester, New York

BACKGROUND (CERTIFICATIONS, LICENSES, ETC.)

Licenses:

- Arizona R.N. License #: R.N.133845
- New York R.N. License #: 290061-1
- Certified Case Manager # 00078212

Certifications:

- Certified Case Manager, October 2004
- Quality Management Certified, May 2003
- Care Management, February 2002
- Disease Management, Train the Trainer, April 2002

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Barry Stephen Markman, M.D., F.A.C.S, MBA
Medical Director

EMPLOYMENT HISTORY

Medical

Senior Medical Director Aetna Medicaid - SIU, 2015 - Present

- Medical Director Support SIU

National Quality Forum Standing Committee – Surgical Measures, 2014 – Present

- National Quality Forum Standing Committee

Medical Director Coventry / Aetna Kentucky Medicaid, 2012 – 2014

- Case / Utilization / Current Review Management

Contract Medical Director Anthem, CO / NV, 2010 – 2012

- Utilization Management

Barry Markman MD Board Certified Plastic / Reconstructive Surgeon, 1986 – 2001

- Private Practice in Reconstructive and Cosmetic Surgery

FINANCIAL PROFESSION

Markman & Associates, Ltd., 2003 - Present

- NEXT: Investment Advisor /Registered Representative CRD: 4621581, 2007 - 2008
- I Realty- Business Broker, 2007 - Present
- I Realty Real Estate Broker/Salesperson, 2006 - Present
- Management of personal issued Patents

EDUCATION

UNLV Master of Business Administration, 2006

Las Vegas, Nevada Venture Capital Concentration

UNLV Paralegal Program, 2001Fellow American College of Surgeons, 1993

American Board of Plastic Surgery, 1991

Plastic Surgery Fellowship, 1984-1986

University of Texas Southwestern, Dallas, TX

American Board of Surgery, 1986

General Surgery Residency, 1979-1984

University of Texas Southwestern, Parkland Hospital - Dallas, TX

Doctor of Medicine AOA - Medical School Honor Society, 1975-1979
New York University Medical School, New York, NY

Summa cum laude (Economics), 1971-1975
Phi Beta Kappa 1971-1975
Union College, Schenectady, NY

BACKGROUND (CERTIFICATIONS, LICENSES, ETC.)

Licenses

- Insurance NV Resident: Life Health Property Casualty Annuities, #166468
- Real Estate NV: I Realty Broker Salesperson, # 58169
  NV: Business Broker, # 317

Medical Licenses: Active Unrestricted

- NV, 5405
- KY, 45656
- PA, MD447216
- FL, ME115187
- NY, 209889
- IA, Pending Final Review

Professional Organizations:

- American Society of Plastic & Reconstructive Surgeons, 1991-Present
- American Society for Aesthetic Plastic Surgery, 1994-Present
- American Medical Association, 1991-Present
- Fellow American College of Surgeons, 1991-Present
- Clark County Medical Society, 1986-Present

Chandra Kee, MD
BH Medical Director

EMPLOYMENT HISTORY

Senior Medical Director, National Medical Management, 2014 – Present

Aetna Medicaid

- The Senior Medical Director (MD) is responsible for leadership of strategic medical management activities which contribute to the performance of Aetna Medicaid and promotes quality of care for our members. These responsibilities include:
  - Development and implementation of medical programs/policies, enhancing relationships with providers and facilities, community partners, and regulatory agencies.
  - Acts as a key business partner in network development, product design, strategic planning, and quality improvement.

Vice President of Medical Affairs, Medicaid & Special Needs, 2012 – 2014

Coventry Healthcare (an Aetna Company)

- Served as Vice President of Medical Affairs, Medicaid & Special Needs, for the Mid Atlantic region of Coventry Health Care, Inc.
- Provided expertise in medical management by direct decision making in the areas of preauthorization; concurrent review of hospitalized patients; discharge planning; and integrated case management.
- Provided support to the quality improvement and pharmacy programs.
- Analyzed medical cost drivers and developed specific plans to reduce avoidable cost and improve quality of care.
- Worked with Network to develop strategic approaches to improve company performance and expand growth by optimizing the provider network; evaluated provider (hospital; physician; ancillary) contracts; and developed other creative approaches. Provided guidance for all clinical aspects of the program.
- Provided periodic consultation with practitioners in the field as necessary. Helped to ensure a staff of qualified clinicians accountable to the organization for decisions affecting members is maintained; and that appeals are reviewed by non-subordinate Board Certified specialists.

Chief Medical Officer, 2010 – 2012

Aetna Better Health of Pennsylvania (an Aetna Medicaid Plan)

- Responsible for leadership of strategic medical management initiatives which contribute to the performance of the markets and promote quality of care for our members.
- Recruited physicians for the Utilization Management and Pharmacy and Therapeutics committees.
- Developed Preventable Readmissions and Patient Centered Medical Home pilot programs.

- Participant in external constituent workgroups including a partnership with the *Smoke Free Philly* initiative with the Philadelphia Department of Public Health and the Philadelphia Department of Public Health Policy Group.

Behavioral Health Medical Director, 2007 – 2010

Delaware Physicians Care (an Aetna Medicaid Plan)

- Medical Director for Delaware Physicians Care (DPCI), an Aetna Medicaid Plan. DPCI was the largest managed Medicaid plan in Delaware and one of the top 25 Medicaid plans in the country.
- Developed, implemented, supported, and promoted Health Services strategies, tactics, policies, and programs that drive the delivery of quality healthcare in a cost effective manner to establish competitive business advantage for Aetna.
- Responsible for providing clinical expertise and business direction in support of medical management programs to promote the delivery of high quality, constituent responsive and cost effective medical care.
- Performed utilization management reviews (pre-certification, concurrent review, retrospective review) for both behavioral health and physical health using evidence-based medical necessity criteria.
- Worked with the Manager of Prior Authorization to improve performance on our NCQA denial audits and achieved a score of 100% for the first time in history.
- Provided clinical guidance in operating effective medical programs to promote member quality of care and in reviewing potential lapses in the quality of care.
- Worked collaboratively with other functional areas that interface with medical management including provider relations, contracting, member services, benefits and claims management, appeals, and enrollment to achieve the business goals of the company.
- Participated in workgroups, committees, project teams and strategic planning for the company in its mission to deliver comprehensive, holistic, and cost-effective quality care.

Regional Medical Director, 2006 – 2010

Aetna Behavioral Health (formerly Magellan), King of Prussia Care Management Center

- Served as Regional Medical Director for Behavioral Health in the King of Prussia Office serving the Mid-Atlantic and Northeast regions. Responsible for approximately 4 million commercially insured HMO, PPO, Medicare, and traditional plan members.
- Provide medical oversight of Clinical Operations and Quality Improvement areas including Care Management, Complaints & Appeals, and the Specialty and Disease Management programs.
- Provide oversight for medical policy implementation and utilization management services. Participate in the development, implementation, and evaluation of clinical/medical programs. Wrote 2007 Care Management/Utilization Management leadership plan for the service center.
- Participate in NCQA accreditation preparation. Participated in the NCQA MCO accreditation

surveys for the NE region in 2002 and 2006. Achieved perfect score for behavioral health. Chair of the NCQA Preventive Health work group.
- Support sales and marketing efforts including participation in key marketing activities and presentations for the Chairman's Initiative on Depression and Ethnic Disparities in Healthcare.
- Chaired the Aetna Behavioral Health Diversity work group and wrote the first ABH Diversity Plan in 2006.
-

Associate Medical Director, 2000 – 2006

Magellan Health Services, King of Prussia Care Management Center

- Served for two years as Associate Medical Director for the King of Prussia Regional Service Center at Magellan Behavioral Health, and then served as the RSC/CMC Medical Director. The KOP CMC exclusively serviced Aetna, managing the behavioral health benefits for 3.3 million commercial HMO and Medicare members in 4 Aetna regions covering 19 eastern states.
- Provided strong medical and clinical leadership and helped the center through many notable achievements including NCQA and URAC accreditation, expansion of the geographic service area, growth of the high risk care management programs, and evolution of the "Aetna Behavioral Health Clinical Model". Responsible for the medical oversight of utilization management and medical cost containment, staff education, program development, and quality improvement activities.
- Served as Chair/member of the Utilization Management Committee, Quality Improvement Committee, Provider Advisory Group, and the Professional Peer Review Committee.
- Provided clinical supervision for Care Managers, Associate Medical Director, and Physician Advisors.
- Provided medical oversight of the specialty care management programs – Medical Psychiatric Case Management, Behavioral Health Intensive Case Management, and Depression Disease Management programs.
- Responsible for implementation and oversight of two Preventive Health programs.
- Participated in Magellan's Corporate Preventive Health work group which was responsible for reviewing and improving existing preventive health programs as well as developing additional programs.
- Successfully implemented the "Partners in Care" program for the KOP Care Management Center in 2004. Program is a partnership between Magellan and certain high volume and top performing providers in which Magellan removes some of the utilization management activities and partners with the facility to do more case management.
- Successfully lead the Primary Care Physician Education team in training over 400 Primary Care providers in the early diagnosis and treatment of Depression and other mental health disorders.
- Responsible for Antidepressant Medication Management Quality Improvement activity. Worked jointly with the health plan to improve performance on the three HEDIS antidepressant measures.

EDUCATION

Bachelor of Science, 1983
Indiana University of PA, Indiana, PA

Doctor of Medicine, 1987
Robert Wood Johnson Medical School, Piscataway, NJ

BACKGROUND (CERTIFICATIONS, LICENSES, ETC.)

Licenses

- CT, DE, FL, MD, PA, NC, and VA

Certifications

- Board Certified in Psychiatry, American Board of Psychiatry and Neurology

Debra J. Bacon
Chief Financial Officer

EMPLOYMENT HISTORY

Vice President, CFO, 2014 - Present

Aetna Inc.

- Key member of leadership providing strategic direction and operational oversight of Medicaid health plans
- Accountable for the financial performance of the business unit
- Lead the finance team to implement systems and controls to ensure timing and accurate financial reporting
- Collaborate with a team to evaluate new business opportunities, including strategic, operational and financial considerations

Executive Director, Regional CFO (West/Great Plains Regions and Central functions) Central Finance Functions 2007 - Present

Aetna Inc.

- Oversee monthly accounting, reporting and analysis of results for multiple legal entities; support action plans to achieve results. Also manage numerous annual audits and provide materials in support of SEC filings and investor relations
- Provide financial direction and support the ultimate implementation of new health plans
- Lead quarterly forecasting process both in support of the Medicaid business leaders and the larger corporate Aetna operation; partner with individual business units to meet or exceed financial targets
- Built and manage a highly productive and effective team that supports all financial needs of the business. Managed the team through significant change

West Region Functions, 2009 - Present

Aetna Inc.

- Develop and maintain relationship with regulators, auditors and external clients
- Evaluate and implement successful strategy for market growth; take active role in RFP responses and annual contract renewals
- Ensure operational efficiency and financial accuracy. Oversee the teams responsible for accounting, financial analysis, financial reporting, audits and regulatory reporting.

Vice President of Finance, Corporate Controller – 2004 to 2007

Schaller Anderson, Incorporated

- Led corporate finance department including accounting, financial planning and analysis, and financial oversight of centralized service operations
- Improved integration between the finance units to enhance quality of information and improve efficiency

EDUCATION

Masters Degree – Accountancy
University of Nebraska – Lincoln , NE

Bachelors of Science - Business Administration with emphasis in Accounting
University of Nebraska – Lincoln, NE

BACKGROUND (CERTIFICATIONS, LICENSES, ETC.)

Certified Public Accountant

- Active license in Nebraska
- Inactive permit in Florida

Certified Financial Planner

- Inactive license

Patricia Gam Simpson
Compliance Director

EMPLOYMENT HISTORY

Compliance Director, 2015 – Present

Aetna

- Oversight of Compliance staff at four Medicaid health plans; serving as interim Compliance Officer for two Medicaid health plans, including an MLTC plan (NY) and a Regional Behavioral Health Agency (AZ)
- Participation in RFP preparation
- Actively engaged in identifying new talent and serving as a coach/mentor

Compliance Director, 2014

Delaware Physicians Care , an Aetna Company

- Overall responsibility for all compliance functions for Delaware Physicians Care, an Aetna Medicaid plan
- Key member of the health plan senior leadership team
- Developed and managed relationship between the health plan, state Medicaid regulators and other state agencies
- Responsible for contract compliance readiness for a new expanded services state contract
- Worked closely with Operations staff and Aetna's fraud, waste and abuse unit to improve and enhance monitoring and oversight in accordance with CMS/OIG/state Attorney General requirements
- Serve as a mentor to new compliance professionals within Medicaid Compliance as well as the larger Aetna team

Senior Consultant, 2013-2014

The Lewin Group

- Responsibilities included supporting the Massachusetts Health Exchange as a Medicaid policy subject matter expert
- Supporting the implementation of the Centers for Medicare & Medicaid Financial Alignment (Duals) demonstrations through development of readiness review protocol
- Providing program and policy evaluation and feedback for multiple state Medicaid programs

Compliance Director, 2008-2013

Aetna

- Responsible for the oversight and coordination of all compliance and regulatory activities for eleven Medicaid health plans nationwide
- Successful integration and realignment of Medicaid Compliance unit to a matrixed organization after acquisition
- Responsible for escalating compliance issues to senior leadership and resolving issues

- Duties included the development and implementation of Compliance and Ethics policies and procedures
- Oversight of implementation of new regulations and contract requirements, including the development of reporting tools
- Oversight of all Medicaid external quality review audits and any subsequent corrective action plans
- Management of internal compliance related risk assessments and corrective actions, internal audits and corrective action plans
- Management and development of a staff of thirteen nationwide
- Member of implementation lead teams for six new Medicaid health plans, including two MLTC plans
- Created a process to review claims data aimed at reducing provider fraud
- Served as Privacy Officer for the Medicaid line of business which includes monitoring of all privacy-related issues
- Development and coordination of staff training, submission of required reports to CMS/OIG/Program Integrity Audits and responding to internal/external privacy inquiries
- Managed the integration of Aetna's fraud and abuse program into the Medicaid line of business

Compliance Manager, 2005-2008

Delaware Physicians Care, an Aetna Company (formerly Schaller Anderson)

- Responsible for the development, coordination and operation of the health plan's compliance program
- Developed and managed relationship between the health plan and state regulators
- Attended state legislative budget hearings
- Work collaboratively with management and executive staff to ensure full compliance with all legal, quality assurance and regulatory requirements
- Responsible for the oversight of all legal activities related to the health plan including coordinating inside and outside counsel
- Attended health plan Board of Directors meetings, providing reports and summarizations of compliance activities and issues
- Developed a "provider VIP" program to research and remedy provider's claims payment issues
- Responsible for the start-up and operations of a Medicare Special Needs Plan for dual eligibles, including a Part D component
- Developed and monitored a process for identifying, investigating and reporting provider fraud and abuse in accordance with CMS/OIG/state Attorney General requirements

EDUCATION

MBA, Health Care Administration

Wilmington University, New Castle, DE

BS, Business Management

Wilmington University, New Castle, DE

Associate of Applied Science, Management/Marketing
Delaware Technical and Community College, Dover DE

BACKGROUND (CERTIFICATIONS, LICENSES, ETC.)

Professional Affiliation

- Health Care Compliance Association

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Ted A. Cummings, R.Ph., MBA
Pharmacy Director/Coordinator

EMPLOYMENT HISTORY

Director, Medicaid Clinical Pharmacy, 2014 – Present

COVENTRYCARES OF KENTUCKY , An Aetna Company

- Provided leadership for Plan Pharmacy Directors
- Established and implemented strategies for efficient and effective pharmacy benefits within Medicaid
- Participated in all elements of RFP process
- Led pharmacy team during RFP and go-live for new Plans

Regional Clinical Pharmacy Director, 2011 – 2014

COVENTRYCARES OF KENTUCKY , An Aetna Company

- Served as First Regional Clinical Pharmacy Director for Managed Medicaid Plan
- Implemented programs that have resulted in significant cost reductions
- Developed Pharmacy Policies and Procedures
- Developed and successfully organized initial Pharmacy and Therapeutics Committee
- Overcame unexpected challenges during the implementation phase for the Plan
- Developed effective working relationships with physicians, pharmacists throughout the Commonwealth
- Overcame initial negativity to develop very strong relationships with both the Medicaid and Behavioral Health Departments within the Commonwealth
- Implemented a generic Suboxone program that has produced over $6.7 million in savings.
- Provided leadership during very stressful times
- Awarded Chairman's Award in 2014

Clinical Pharmacist, 2009 – 2011

CATALYSTRX

- Responsible for development of the Med D formulary
- Implemented programs that resulted in a 10% reduction in PMPM costs with minimal member dissatisfaction
- Developed programs that met all CMS guidelines for a Med D Plan.
- Implemented an MTM program in conjunction with KPhA

Senior Clinical Pharmacy Manager, 2006-2007

CEPHALON, INC.

- Managed all Medicaid and Managed Care Accounts, including the Humana national account, for IN, KY, MI

- Implemented an effective pull-through strategy that increased annual sales at Anthem by over 35% in KY and 25% in IN
- Developed a structured and systematic system of reviewing reports that contributed to outpacing annual national third party share growth for Provigil at targeted accounts
- Developed and presented several plan specific training programs for representatives that led to improved sales at difficult accounts
- Account relationships: State Medicaid and WellPoint – MI, IN, KY; Humana – national; various regional accounts

Senior National Account Executive / Customer Manager, 1993-2005

MERCK, INC.

- 1 of 4 National Account Executives selected and trained to work with Regional Account Executives to negotiate both internally (with attorneys and product managers) and externally (with customers) to achieve market share driven product agreements. Responsible for regional commercial and state Medicaid accounts in AL, FL, KY, MS, OH and TN
- Led negotiations with 12 customers during 3 year period

EDUCATION

MBA

University of Kentucky, Lexington, KY

BS, Pharmacy

University of Kentucky, Lexington, KY

BACKGROUND (CERTIFICATIONS, LICENSES, ETC.)

Licenses

- Registered Pharmacist, KY – license # 7922

Patrice Stevens
Grievance & Appeals Manager

EMPLOYMENT HISTORY

Director of Appeal and Grievance, June 2014 – Present

Aetna Inc.

Accountable for the design, development and implementation of member and provider appeal and grievance programs for new Medicaid and Integrated Duals health plans as well as the ongoing management and support of appeal and grievance systems and processes for Medicaid and Integrated Duals plans.

- Ensure accuracy of Appeal and Grievance (A&G) RFP responses.
- The design, development and implementation of the A&G program for all new health plans.
- Monitoring and auditing of Aetna MBU health plan member and provider appeal and grievance system programs and processes.
- Monthly monitoring of resolved appeals and grievances.
- Full Bi-Annual assessments of Medicaid and Integrated Duals plans.
- Ongoing oversight to identify risks and potential issues.
- Development of activities to address any identified risks and issues to minimize or mitigate compliance risk for the organization.
- Support of the Medicaid health plan's grievance and appeal processes and case specific questions.
- Facilitate the configuration and migration to the Aetna Medicaid Administrators enterprise wide A&G application.
- Manage A&G application support.
- Serve as liaison the executive complaints and triage to the appropriate plan for resolution within 24 hours.

Implementation Sr. Project Manager, February 2010 – June 2014

Aetna Inc.

Accountable for the development, implementation and ongoing management of more complex projects for new health plan implementations which typically impact more than one of the following: process, system, product and/or function and may run a year in duration.

- All aspects of new health plan implementation for the following segments; informatics, actuarial, compliance, pharmacy and medical management
- Identifies gaps and recommends enhancements related to new and/or existing products, services and workflows based on broad view of the organization
- Solicits and evaluates internal and external customer feedback to enhance continuous quality improvement
- Responsible for managing the budget and/or financial implications of more complex projects
- Group facilitation/presentation influencing various internal (these may be cross-functional/segment) and external parties (e.g., vendor management)
- Identifies issues that may stall project and addresses them by either resolving the issue or creating

an alternative solution
- Tracks progress and communicates project(s) status on a regular basis to all impacted parties
- Builds communication plans for implementation to ensure all impacted parties (upstream/downstream) are informed of next steps for completion

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Manager of Quality & Compliance, March 2007 – January 2010

Aetna Inc.

Responsibilities span across all aspects of quality management, data integrity, contract and HIPAA compliance including review of all recipient and provider materials.

- Ensure compliance of day to day operations with contractual and related regulatory requirements
- Review utilization management processes for compliance with HIPAA guidelines
- Review of all written and oral communications with recipients and providers
- Corporate HIPAA liaison for New Hampshire
- Provide HIPAA training for New Hampshire staff
- Manage all aspects of appeals & complaints: review and triage, data tracking, trending and reporting
- Ensure alignment of processes with NCQA standards where applicable
- Manage all aspects of contracted selected HEDIS reporting.
- Develop and implement activities related to HEDIS, Preventive Health or Utilization, including QIA studies, interventions, and data analysis and training tools.
- Promote preventive health
- Coordinate and Manage local, multi departmental and multi plan projects as assigned
- Database creation, entry, and maintenance
- Analyze data and processes to identify improvement and opportunities
- Drive results through Continuous Quality Improvement

Senior Management Analyst, October 2006 – March 2007

State of New Hampshire, Office of Medicaid Business and Policy

- Analyzes and evaluates current management methods and procedures and recommends necessary changes in organizational structure, performance criteria and administrative policie.
- Supervises collection of statistical data needed, develops statistical reports and draws conclusions used by program planners and managers in administrative decision making
- Develops agency wide policy manuals covering all areas of administration and assists administrative staff in the establishment of policy manuals covering the specific operations of their respective units
- Coordinates agency programs to insure efficient use of material, facilities, training and data to provide maximum services
- Develops formal lines of communication between agency personnel including providing information instructions and directives in order to attain cooperation and fulfill agency objectives

Director Clinical Quality Programs, North Region, September 2004 – January 2006

CIGNA HealthCare

- All responsibilities are regional in scope and span across 9 health plans covering approximately

800,000 commercial and PPO members, including staff management who are located across multiple states
- Lead and coordinate national projects across matrix partner divisions
- Analyze data and processes to identify improvement and opportunities
- Drive results through Continuous Quality Improvement
- Coordinate and Manage local, multi departmental and national projects
- Coordinate and track RFP responses
- Participate on multiple internal and external committees/teams
- Chair Clinical Quality Improvement Committee
- Ensure compliance with regulatory requirements, NCQA Preventive Health, Medical Records and Quality Improvement standards
- Manage all aspects of HEDIS reporting including: staff, productivity, data collection, vendor contracting, training, reporting, pre-audit preparation, annual audit, verification of results throughout the process and prior to NCQA submission
- Vendor contract negotiation and execution
- Develop and implement activities related to HEDIS and Health Management, including QIA studies, interventions, and data analysis and training tools.
- Promote preventive health
- Share Quality/HEDIS intervention best practices and influence implementation at other CIGNA health plans
- Manage all aspects of Disease Management or preventive health program design, development, implementation and analysis of effectiveness
- Written and oral communications with physicians and members

EDUCATION

B.A. – Family Studies

University of New Hampshire, Durham, New Hampshire

BACKGROUND (CERTIFICATIONS, LICENSES, ETC.)

- New Hampshire Justice of the Peace
- Previously held a New Hampshire Life and Health Insurance License
- Drafted HEDIS reporting rules to accompany new New Hampshire legislation reporting requirements
- Selected by NCQA two years in a row to Field Test proposed HEDIS measures
- Co-led development of CIGNA's national Targeted Health Education (THE) program
- CIGNA Presidents Club award
- Five CIGNA Circle of Excellence Platinum awards and nine CIGNA Circle of Excellence Gold awards
- Influenced and collaborated with the national HEDIS and Quality teams to expand two programs developed locally, nationally in 2001
- Participation on multiple state specific committees to improve targeted care in New Hampshire and Vermont

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Kim Herink
Quality Management Director

EMPLOYMENT HISTORY

Director of Quality Management, 2005—Present

Aetna Inc.

- Responsible for the oversight and coordination of Medicaid corporate and affiliated health plans quality management programs and activities, including: risk management, patient safety, credentialing, accreditation, practitioner peer review, external quality review organization evaluations, quality focus studies, and improvement projects

Quality Management Coordinator

Aetna Inc.

- Responsible for quality management functions related to credentialing, delegation, accreditation, and other quality improvement activities, including HEDIS
- Analyzed quality trends and outcomes for medical management/disease management programs, and integrated data into the development of quality management programs

Quality Improvement Specialist, 1998—2005

Intermountain Health Care (IHC)

- Coordinated and facilitated the development, implementation, evaluation, and reporting of quality management activities for the health plan
- Implemented NCQA quality-improvement standards, department objectives, and IHC corporate goals
- Collaborated across departments to conduct HEDIS audits, and to implement HEDIS process development and improvement activities

Manager, Utilization Management Department, 1996—1997

Talbert Medical Management

- Planned, staffed, directed, and managed daily departmental activities
- Monitored providers' practice patterns to identify areas of non-compliance with utilization management policies and procedures
- Responsible for conducting weekly utilization meetings with all Talbert primary care providers
- Oversaw the education of internal and external providers on utilization practices to ensure cost-effective, high-quality care
- Designed an authorization process that placed primary care providers in control of utilization for their patients

EDUCATION

Business Management

University of Phoenix, Ogden, Utah

Registered Nurse

Missouri Baptist Hospital School of Nursing, St. Louis, Missouri

BACKGROUND (CERTIFICATIONS, LICENSES, ETC.)

Licenses

- Registered Nurse in the state of Arizona, with multistate privileges

Certifications

- Internal Claims Association designation of Associate, Life and Health Claims (ALHC)
- Health Insurance Association of America designation of Health Insurance Association (HIA)
- Health Insurance Association of America designation of Managed Healthcare Professional (MHP)

Awards

- 2002 George W. Merck Quality Award for IHC Health Plans Cholesterol Management Program

Sherry Logan
Utilization Management Manager

EMPLOYMENT HISTORY

National Medicaid Senior Director, Utilization Management (UM) – March 20, 2015 to Present

Aetna, Inc.

- Oversight responsibilities for National UM Department
  - Development / Management of UM Standard Operation Model
  - Development / Management of UM Standard Staffing Model
  - Co-chairperson UM Steering Committee
  - Oversight of UM functions and support for new Business Implementations and existing health plans
  - Business Owner of Automated Prior Authorization Tool (CWQI)

National Medicaid Director, Clinical Program Development – March 2014 through March 19, 2015

Aetna, Inc.

- Providing leadership and direction in the development, enhancement and implementation of clinical initiatives / programs.
- Developing policies, procedures, standards, program descriptions, program goals and objectives to effectively restructure business processes to achieve economies of scale and improved business efficiencies.
- Working collaboratively with other departments to evaluate the health status of members; including monitoring and evaluating program effectiveness.
- Serving as National Medicaid Medical Management Culture Advocate Lead in support of Aetna's values: Integrity, Excellence, Inspiration and Caring.

Corporate Medicaid Director, Health Services – May 2012 through March 2014

Coventry Health Care, Inc.

- Providing oversight of the Medicaid Clinical Condition Management Programs; including Asthma, High Risk Obstetrics and High Risk Neonate for (9) health plans.
- Providing leadership and direction in the development, enhancement and implementation of clinical initiatives / programs; ensuring that program development processes are intertwined with all functional areas in order to ensure that organization short and long term goals are met.
- Providing management oversight of the Corporate Medicaid Manager, Health Services.
- Providing oversight of the development and coordination of the Corporate Medicaid Medical Director clinical training orientation program.

Corporate Medicaid Director, Health Services, Manager, Training / Auditing – December 2009 through May 2012

Coventry Health Care, Inc.

- Providing oversight of auditing / training activities for nine Medicaid Health Plans and one Centralized Prior Authorization Call Center within the Corporate Medicaid Division.
- Interviewing, hiring, supervising and evaluating three full time nurse auditor / clinical trainer positions.
- Providing oversight of development, implementation and evaluation of annual auditing and training plan for the Medicaid Division.
- Providing oversight of development, implementation and evaluation of training work plans for new Medicaid business plans; development / maintenance of system and process training documentation; development / maintenance of auditing / training access database for tracking / trending / reporting purposes
- Functioning as the liaison to Medicaid Health Plan Senior Leadership to ensure effective communication.
- Providing oversight of the Corporate Medicaid Asthma Condition Management Program; including functioning as the Project Manager; responsible for conducting monthly Team meetings; facilitating and monitoring health plan implementation of the program.

Quality Improvement Manager – April 2009 through December 2009

Pennsylvania Department of Public Welfare

- Providing oversight of a Medicaid Enhanced Primary Care Case Management / Disease Management Program for Fee-For-Service population.
    - Drafted automated Corrective Action Plan to be used within a Quality / Monitoring access database.
    - Drafted Desk Top Procedure documents related to quality initiatives.
    - Participated in the review of the clinical components of an RFP for an Enhanced Primary Care Case Management / Disease Management Program for Medicaid Fee-For-Service enrollees.
- Functioning as project manager for the development / planning for a national webinar.

National Medicaid Team Manager, Health Services – August 2008 through April 2009

Coventry Health Care, Inc.

- Providing oversight responsibilities for assisting with preparation for the URAC accreditation survey for Fee-For-Service Medicaid Health Care Management Department.
- Assisting with the identification and development of Performance Improvement Projects.
- Providing oversight of staff members including a Quality Improvement Manager, Quality Improvement Specialist and a Health Services Manager of a Medicaid Medical / Surgical State Contract.

- Assisting with documentation of business requirements for a Health Care Management application system.
- Assisting with responses to State Medicaid RFI's and RFP's.
- Functioning as Member of Health Care Management Quality Improvement Committee responsible for oversight of five state Medicaid contracts.

National Medicaid Team, Health Care Consultant – March 2008 through August 2008

Coventry Health Care, Inc.

- Assisting with the responses to State Medicaid RFP's; specifically Health Choices Medicaid for Pennsylvania.
- Drafting Medicaid template documents such as a Medicaid Quality Improvement Program Description, Medicaid Quality Improvement Work Plan, and Medicaid Quality Improvement, Medical Management, and General Operational Policies and Procedures.

Medical Management, Health Care Consultant – October 2006 – March 2008

Coventry Health Care, Inc.

- Providing Project Management oversight for the development and implementation of 16 Disease Management programs.
- Assisting with the development and implementation of a Clinical Rules Engine to identify and stratify Disease Management Program membership.
- Assisting with the development and implementation of compliance measure trend reporting for 16 Coventry Health Plans and National Accounts.

ACCESS Plus Project Manager Pennsylvania Medicaid – March 2005 through October 2006

Quality Insights of Pennsylvania (State QIO)

- Providing quality oversight project management to McKesson / PA Department of Public Welfare Contract (ACCESS Plus Disease Management Program for Medicaid beneficiaries in 42 counties of Pennsylvania).
- Providing overall integration between all tasks and projects through the establishment of standards, protocols, tools, processes and knowledge transfer mechanisms.
- Functioning as a liaison between project participants to ensure effective communication, increase work group efficiency and reduce the risk of project failure.
- Completing and coordinating program management reports against established work plans.
- Developing policies and procedures to ensure tasks are coordinated, controlled, managed, and integrated.

Education

Registered Nurse (Diploma) (3 year program)

St. Joseph's Hospital School of Nursing, Lancaster, Pennsylvania (Graduated 1979)

BACKGROUND (CERTIFICATIONS, LICENSES, ETC.)

Licenses

- Registered Nurse (RN)

Certifications

- Mental Health First Aid

Heather Koch
Behavioral Health Manager

EMPLOYMENT HISTORY

Head of Clinical Programs, 2013 – Present

Aetna Behavioral Health Public Sector

- Create and support the Behavioral Health services and programs for Aetna Medicaid, i.e., Behavioral Health "Blueprints" for new and existing Medicaid business. Act as a behavioral health Subject Matter Expert for RFP responses and business development
- Oversee and lead the development of products that integrate physical health, behavioral health and psychosocial functioning into clinical programs with supporting tools and technologies
- Oversee the implementation and on-going execution of the strategic and operational business plan for clinical operations and/or plan sponsor operations. Coordinate business segment policies and procedures in support of financial, operational and service requirements
- Lead multidisciplinary teams to create products that are ready for implementation in Aetna Medicaid markets
- Work with data and information systems, in collaboration with the Informatics department, to develop algorithms for behavioral health staffing recommendations based on Medicaid populations and lines of business

Cenpatico of Arizona Medical Management Administrator, 2006 – 2013

Centene Corporation

- Manage Cenpatico (CAZ) Medical Mgt. team who manage behavioral health benefit utilization for AHCCCS Regional Behavioral Health, Bridgeway (BHS) Health Services Long-term Care Medicaid and Medicare Advantage plans
- Develop, review and revise all Medical Mgt. policies and procedures on an annual basis and as needed. Ensure all policies are compliant with State Medicaid, CMS Medicare regulatory requirements and URAC standards
- Identify medical management trends and develop targeted interventions as needed. Monitor over and under-utilization trends
- Develop, administer, and co-chair Medical Mgt. committees for CAZ and BHS. Monitor and report medical management data and trends at both the Medical and Quality Mgt. committees
- Educate agency and subcontractor staff on CMS Medicaid/Medicare and URAC medical management requirements. Ensure compliance with CMS and URAC requirements in all medical management functions
- Track medical management denials and appeals. Ensure all coverage determinations are compliant with Medicare, Medicaid and URAC standards to include all appeal options
- Compile, review, and disseminate multiple reports on Medical Mgt. operations for statistical and financial tracking. Design report formats for effective delivery of key data elements
- Develop and maintain the annual Medical Management Plan and Work Plan for submission to the State of Arizona

- Business owner for all Medical Mgt. reports to the State of Arizona, to include compliance oversight of Quarterly Indicator reports and data accuracy.
- Project lead and manager for URAC accreditation renewals.
- Active participation in development and submission of RFP proposals for multiple Centene lines of business

Care Management Supervisor, July 2000 – April 2003

Cigna Behavioral Health (CBH), July 1996 – April 2003

Cigna

- Senior manager of a clinical team in a multi-state call center serving over 1 million covered lives. This team managed the Medicare contracts combined with Medicaid and commercial contracts
- Managed a team of 10 clinicians that handled crisis calls and the behavioral health benefits for a population of 450,000 covered lives within the call center
- As the senior Manager, was appointed as the acting Clinical Administrator for several months. Additional duties included: Risk Management reports; data compilation for the Regional Care Director to utilize for Senior Management reports; fielded and resolved escalated customer service issues; supervised all regional clinical rounds
- Ensured staff compliance with multi-State, Medicare, Medicaid, URAC and NCQA standards and regulations for all aspects of medical management
- Conducted numerous trainings for several teams at the Regional Care Center that included: systems upgrades; revised protocols; regulatory compliance; market specifications; and customer service
- Established and maintained a very close working relationship with several departments of the Arizona Health Plan via monthly Service Coordination meetings and the Senior Advisory Council. Conducted several training sessions for the Health Plan case managers to improve interactions with CIGNA Behavioral Health
- Involved in monthly Quality Review Team meetings to evaluate re-credentialing providers' performance levels and address provider Concerns/Complaints/Grievances
- Participated on the national Credentialing Committee to review provider issues that included: Board Sanctions; License/Certification terminations; legal investigations

EDUCATION

Master's – Counseling

University of Phoenix, Phoenix, AZ (CACREP approved program)

B.A. – Psychology

Ottawa University, Phoenix, Arizona

BACKGROUND (CERTIFICATIONS, LICENSES, ETC.)

Licenses

- Licensed Professional Counselor, State of Arizona, LPC, since May 199

Michelle Duncan
Member Services Manager

EMPLOYMENT HISTORY

Project Manager, 2013 – Present

Aetna, Inc.

- Acting Member Service Manager during Health Plan Implementations
  - Review new health plan requirements and prepare policies and procedures specific to Medicare regulations and state Medicaid contract. Collaborate with various functional departments to ensure member services department staff is properly equipped, trained, and ready to serve members prior to health plan implementation date.

Member Services, 1999 – 2013

Regence BlueCross BlueShield of Oregon

- Project – Customer Relationship Manger Consolidation
  - Migrated Company from Onyx CRM to Salesforce.com
- Project – Membership Information Tool improvement
  - Review and ready all online membership division documentation in preparation for switch to Consona online knowledge management infrastructure system.
- Project – Legal and Regulatory Compliance
  - Analyzed Federal and State Mandates for impacts to Membership Department
- Project - Online Enrollment
  - Executed promotion for web based self-enrollment to reduce per member per month admin costs.
- Project – System integration
  - Migrated four states with separate membership enrollment and claims adjudication systems to one common platform.
- Project - Improve BlueCross BlueShield Association Member Touchpoint Measure scores (MTM)
- Supervisor – Member Services
- Performance Integrity Analyst

EDUCATION

Business Administration/Paralegal

Heald College, Portland OR

Management and Supervisory Development

Portland Community College, Portland OR

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Donette Koehler
Provider Services Manager

EMPLOYMENT HISTORY

Senior Project Manager – Provider Relations, 2010 – Present

Aetna Inc.

- Accountable for the development, implementation, and ongoing management of more complex provider relations projects, which typically affect more than one of the following: process, system, product and/or function and may run a year in duration. Projects include but are not limited to, TANF/CHIP, Medicare-Medicaid Dual Eligible (Duals), Waivers, Medicare Part D, Medicaid, and Long Term Care etc.
- Supports the provider relations business by recommending appropriate actions, strategies, and/or alternatives to meet business needs. Including the responsibility for leading/managing all aspects of a project and or program such as planning, coordination, development, implementation including the financial implications while prioritizing work, resources, and time. Ensures the end state of the project and/or business operations meets business objective(s) and that all deliverables and due dates are met. Highly collaborative process often requires managing relationships across the segments or multiple functional areas.
- Supports the development of new business provider relations departments, acts as the provider relations manager until hired, responsible for hiring provider relations staff, developing provider materials which includes but is not limited to the provider manual, department policies and procedures, desktops, provider training materials etc.

Product Implementation/Development Manager, 2007-2008

Insurers Administrative Corporation (IAC)

- Primarily responsible for creating clear and attainable project objectives for medium to large projects as well as building the project requirements, and managing the triple constraint for projects, which is, cost, time and scope. Drafts, coordinates and updates all established product implementation documents, which define and clarify procedures for all parties involved and ensures consistency among the various supporting materials. Works in tandem with the Rates Implementation Manager to ensure complete direction is provided to Information Systems for both software and administrative systems implementation of product and rate changes.
- Responsible for ensuring quoting software follows functional specifications as well as being involved with usability testing including identifying aspects of the design to be tested, reviewing the proposed test scripts, and providing final signoff and release approval on quoting software products. Appointed as SharePoint Liaison. Trained a group of SharePoint trainers who facilitated trainings throughout the company. Also responsible for site structure, data mapping and determining business needs for each department at IAC.

Benefits Project Manager/Analyst-Vendor Management (Project Manager), 2004-2007

State of Arizona, Benefit Services Department (Benefit Options)

- Vendor Management - This duty included but was not limited to enforcing contractual obligations along with ensuring performance measurements are being satisfied per the RFP/Scope of work for the following vendors: Medical + Medicare, TPA, FSA, Dental, LTD and STD. This also includes conducting weekly vendor meetings with Mercer Consulting and the Vendors to resolve plan performance issues and operational issues that prevent the plan from running smoothly. Plan recommendations, Section 125 comparisons, and high-level Legislature reports.
- Project Management - This duty included but was not limited to the management of small to medium projects that primarily focused on vendor workers comp claim recovery and vendor performance guarantees. Responsible for planning the work according to the objectives, estimating resources, organize work, direct activities, forecast future trends in project, communicate with business sponsor as well as knowing how to close the project and providing the debrief.

BACKGROUND (CERTIFICATIONS, LICENSES, ETC.)

Licenses

- Accident / Health Producer – License # 173261
- Notary – Commission # 294053

Certifications

- Microsoft SharePoint Certified (Implementing SharePoint Server 2007) 7/2007

Rhiannon Yandell
Information Systems Manager

EMPLOYMENT HISTORY

Systems Implementation Manager, 2015 – Present

Aetna Medicaid Administrators

- Direct the implementation and delivery of information and transaction products through education, user technology, organizational methods and procedures;
- Define business requirements and monitor those through to implementation;
- Act as a business technical expert with the planning, development and validation of master and detail test plans and strategies;
- Monitor projects on an ongoing basis, evaluating progress and quality, managing issue resolution process and taking corrective action as necessary via standard project reporting methods;
- Collaborate with all cross-functional team members/system owners to accomplish required tasks and provide project updates;
- Anticipate delays and initiate plans and alternative solutions;
- Act as health plan liaison to Information Systems Department to ensure timeliness and integrity of all health plan file exchanges between regulators and delegated vendors;
- Act as health plan liaison to regulators and delegated vendors for secure file transfer and detailed file exchange processes.

Manager, Business Information Management and Analysis, 2012 – 2014

Aetna Better Health of Illinois

- Direct the implementation and delivery of information and transaction products through education, user technology, organizational methods and procedures;
- Oversee and assist staff with creating complex queries, complex technical programming, and complex applications;
- Influence change/enhancements to business processes, policies and system infrastructure to improve information quality, availability and access;
- Anticipate potential impacts of infrastructure, application and environmental changes to supported and related systems;
- Work cross-functionally to evaluate new projects and determine their impact on the enterprise computing environments;
- Responsible for team commitments to quality and on-time deliverables;
- Make recommendations about data collection methods, metrics definition and evaluation methods;
- Provide tool and product training support as required to appropriate customer groups;
- Conduct routine quality assurance audits on backend processes in business applications.

Senior Business Analyst, 2001 – 2011

Sage Technologies

- Developed business requirements and rules for new projects;
- Created training manuals and provided fundamental training to new staff in Information Technology and Analysis Departments;
- Created and audited Physician and Hospital fee schedules;
- Reviewed and implemented annual Medicare Physician Fee Schedule changes;
- Reviewed and implemented quarterly drug and immunization pricing changes, including Medicare Part B Average Sales Price and Redbook Average Wholesale Price;
- Audited efficiency and quality of Client Services staff and programs;
- Reconciled annual hospital accounts receivable and capitation payments;
- Calculated and distributed annual Physician bonus payments based on quality and quantity of care;
- Created audit reports to ensure all Medical claims are paid according to contract and fee schedule;
- Created and maintained member benefit plans, including individual and family copayments, maximums and coverage;
- Created client report packages for Executive Department;
- Developed reporting and evaluation process for Clinical Quality Improvement, including HEDIS and CMS Physician Quality Reporting Initiative.

EDUCATION

Technical Training

Entre Computer Solutions, Rockford, IL

Colleen Gurule
Claims Administrator

EMPLOYMENT HISTORY

Operations Head, 2011 – Present

Aetna Inc.

- Medicaid claims
- Provider customer service
- Medicaid encounters

Director, Encounters, 2007-2011
Director, Operations Process and Knowledge Management 2007-2011

Aetna Inc.

- Managed the encounter processing system, process and analysis, project management, and system and configuration testing
- Responsible for claims quality review, training, operations analysis and reporting for Aetna Medicaid operations

Manager, Business Application Management, 2003-2005

Aetna Inc.

- Managed the configuration of new health plans, the conversion of existing plans and the oversight of the administrative systems (i.e., Trizetto's QNXT™ software) for 11 health plans

EDUCATION

Studies in Early Childhood Education

Grand Canyon College, Phoenix, AZ

BACKGROUND (CERTIFICATIONS, LICENSES, ETC.)

Certifications

- Professional, Academy for Health Care Management (PAHM)

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Kelly DeFrancisco, MSW, LCSW, ACSW
Care Coordination Manager

EMPLOYMENT HISTORY

National Director of Integrated Care Management, 2013 – Present

Aetna Inc.

- Oversight and responsibility for all standard ICM program components; policies, procedures, staffing models, NCQA compliance, audit tools, new program development.
- Chair the CM Steering Committee which brings key issues to Medicaid leaders related to care management.
- Provide leadership support to clinical leaders with Aetna Medicaid health plans related to care and chromic condition management.
- Serve as ICM subject matter expert for RFPs and new business development.
- ICM focal point for integration and migration activities related to the acquisition of Coventry Healthcare.
- Clinical ICM lead in the development of programs for duals demonstrations projects and the regional behavioral health authority (RBHA).
- Member of the leadership team to integrate disease and care management programs and platforms.
- Oversight of training curriculum related to ICM and duals.
- Collaborate with long term services and supports (LTSS) and behavioral health leaders to maintain continuity between care management programs.

Program Manager, Integrated Care Management, 2012

Aetna Inc.

- Key leader in the ongoing development and enhancement of our integrated care management programs (ICM) and in the conversion of 5 Aetna Medicaid plans to the ICM program and platform (MCP, MPC, FL, IL, & DE).
- Serve as the department's clinical representative for the new RBHA high risk CM program development workgroup.
- Clinical ICM lead driving development of program and system requirements for duals demonstrations in OH and IL.
- Co-chair the CM Steering Committee comprised of representatives from each Aetna Medicaid health plan.
- Presented to internal/external business partners (e.g., sales team, chief medical officer) on our integrated clinical programs.
- Led project to clinically integrate UM and CM JVS roles; partnered with Head of Aetna Compensation and health plan leaders to implement.
- Led ICM Redesign's policy workgroup to integrate Duals and Long Term Services and Supports (LTSS) into all policies.
- Led the revision/merging of all ICM desktops to support duals and LTSS, while simultaneously launching a formal annual review process for all departmental procedures.

- Developed file and observational audit tools and reporting capabilities for monitoring of CM staff using NCQA Standards.
- Mentored new clinical team member on various assignments, team projects, and job duties.
- Work with ICM and DM teams to move toward the full clinical integration of these programs.
- Covered for director as needed, for team support, guidance, meeting participation, etc.
- Served as an advisor in the development of new training curriculum and revisions.

Continuum of Care Manager, 2009 – 2012

Aetna Inc.

- Key participant in the development of two major care management (CM) programs for Aetna Medicaid plans (TANF & LTSS) that transformed the diagnosis driven clinical CM program to a person-centered, bio-psycho-social model.
- Responsibilities included research of evidenced based guidelines, clinical program design, system specifications for web-based platform, workflows, policies, procedures, reports and comprehensive training curriculum.
- Gathered input and feedback from key constituents (e.g. state agencies, CMS, health plan partners) on new programs.
- Led the implementation, training support and launch at each Medicaid site.
- Managed the contracts for licensed CM surveys and clinical tools.
- Partnered with HH to develop new hiring tools and CM positions that reflect Medicaid's initiative to integrate member care. Responsible for revision of CM policies and procedures and incorporating NCQA standards into program components. Collaborate with Medicaid partners and RFP team to develop programs that meet their state's specific requirements.

Clinical Services Manager, 2008-2009

Aetna Inc.

- Supervised clinical and non-clinical BH Call Center staff (UM, CM, Crisis): Clinical support, education, quality oversight.
- Monitored UM functions for consistent application of criteria (LOCUS, CALOCUS, ASAM) and regulatory compliance.
- Conducted weekly case rounds with clinical staff and medical director on complex, high cost cases.
- Oversaw denials and appeals processing for behavioral health reductions in service.
- Provided support to health plan sponsors/employer groups and responded to member and provider complaints/issues.
- Reported utilization data for senior leadership; Developed procedures for call center operations.

Supervisor of Utilization Management, 2005 – 2006

Aetna Inc.

- Supervised clinical and non-clinical BH Call Center staff (UM, CM, Crisis): Clinical support, education, quality oversight.
- Monitored UM functions for consistent application of criteria (LOCUS, CALOCUS, ASAM) and regulatory compliance.
- Conducted weekly case rounds with clinical staff and medical director on complex, high cost cases.

- Oversaw denials and appeals processing for behavioral health reductions in service.
- Provided support to health plan sponsors/employer groups and responded to member and provider complaints/issues.
- Reported utilization data for senior leadership; Developed procedures for call center operations.

EDUCATION

M.S.W.
Arizona State University, Tempe, Arizona
B.A. – Psychology
State University of New York at Oswego, Oswego, New York

BACKGROUND (CERTIFICATIONS, LICENSES, ETC.)

Licenses

- Licensed Clinical Social Worker (Arizona), January 2001

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Patricia A. Wright
Long Term Care Manager

EMPLOYMENT HISTORY

Manager, National Long Term Services and Supports, 2015 – Present

Aetna Inc.

- Program design, product development and implementation of new contracts
- Develop health plan policies to comply with Aetna standards and meet state and federal regulations
- Developing credentialing process, participation criteria and on-going monitoring for non-traditional providers
- Provide support to new Health Plan management to achieve their financial goals and strategic objectives

Director of Long Term Services and Supports (LTSS) and Collaborative Programs, 2011 – 2014

DELAWARE PHYSICIANS CARE, an Aetna Health Plan

- Operational implementation lead responsible for the management of key milestones, development of policies and procedures for new LTSS line of business yielding $245 million annual revenue
- Met all DE Division of Medicaid and Medical Assistance (DMMA) April 2012 implementation targets
- Span of control encompasses a team of 72 clinical and operational staff in work at home and office based status responsible for the completion of needs assessments and development of member care and service plans
- Exceed state "rebalancing" goal between membership in nursing facility and home & community based settings and extending tenure of members in a community setting
- Consistently met all regulatory, financial and contractual goals of the LTSS program as demonstrated through successful monthly Division of Medicaid and Medical Assistance reviews and annual External Quality Reviews
- Development and direct oversight of our staff model of Money Follows the Person program. Recognized by CMS staff for our member centered approach
- Surpassed state established Money Follows the Person members discharge goals with minimal re-institutionalization
- Established relationships with leaders of DE Healthcare Association, Ombudsman, Adult Protective Services, LTSS providers and advocacy groups

Director of Collaborative Programs, 2009 – 2011

DELAWARE PHYSICIANS CARE, an Aetna Health Plan

- Partnered with several Behavioral Health therapists to provide counseling services to members in their home and/or day program resulting in increased compliance with follow up care for members screening positive for depression
- Created, designed and implemented Project Chrysalis in collaboration with Crossroads of DE Program goal is to identify pregnant members in addiction that may not seek substance use (SU)

treatment for themselves or any prenatal care prior to delivery and through comprehensive community-based case management access their readiness to change and assist them to engage in substance use treatment and prenatal care

- Project Engage – a collaborative effort on a pilot program with Wilmington hospital and Brandywine Counseling aimed at improving the identification, engagement and referral for treatment of substance abuse for members presenting at the hospital for treatment related to a medical condition. Moved from a pilot to a formally recognized clinical program resulting in significant health cost savings, enhanced patient experience of care and increased outpatient substance use engagement
- Created and implemented multiple statewide programs to identify and engage members who are at risk for high-cost utilization of emergency room visits, medical and psychiatric inpatient admissions and recidivism while increasing members' compliance with primary care and outpatient utilization
- Programs included a field based case management component in partnership with various providers including but not limited to Christiana Care Health System, Horizon House, Connections CSP, Brandywine Counseling, Fellowship Health Resources
- Programs resulted in significant savings to the health plan, outcome expectations and contributed to improved HEDIS measures
- Active participant, as Health Plans behavioral health subject matter expert, in Division of Substance Abuse and Mental Health, Division of Medicaid and Medical Assistance programmatic meetings to develop initiatives to achieve the Department of Justice settlement goals
- Developed our strategy to effectively communicate and coordinate care for our members participating in DSAMH's PROMISE program

Director of Behavioral Health, 2004 – 2009

DELAWARE PHYSICIANS CARE, an Aetna Health Plan

- Provide leadership to clinical and operational team in partnership with Behavioral Health medical director, to effectively manage the behavioral health inpatient and outpatient benefit through employment of prior authorization, concurrent utilization review, discharge planning and case management. Utilize LOCUS and ASAM criteria
- Proactively analyze utilization and financial data to identify trends and implement improvements in clinical workflow as needed
- Collaborated with providers to fill identified service gaps and plan for program growth resulting in many of our providers expanding their programs and scope of services
- Interface with senior members of Medicaid, Division of Mental Health/Substance Abuse, Division of Children and Families, governmental offices and advocacy organizations
- Established a behavioral health advisory board

EDUCATION

Bachelor of Social Work

West Chester University - West Chester, PA

BACKGROUND (CERTIFICATIONS, LICENSES, ETC.)

Professional Affiliations - Member

- Improving Transition of Care Committee, 2013 - 2014
- Unleashing the Potential in Every Delawarean: The Addiction Epidemic Task Force, 2014
- DHSS Health Equity Strategic Planning Committee, 2014

Presentations

- Managed Long Term Services and Supports Intensive, NASUAD 2014 National Home and Community Based Services Conference

Publications and Recognition

- Project Engage: A program to identify and transition medically hospitalized patients into addiction treatment. Addiction Science and Clinical Practice, September 2012
- Project Engage: SBIRT with Medically Hospitalized Patients. MHPA 2012 – 2013 Best Practices Compendium
- Aetna Way Excellence Award Winner 2008 for outstanding performance and demonstration of Innovation
- David Mineta, White House Deputy Director of the Office of National Drug Control Policy, Executive Office of the President recognizes Project Engage as an innovative, bold new substance-abuse intervention program. Presentation September 2011 at Wilmington Hospital

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AETNA BETTER HEALTH® OF IOWA

3.2.7.5 Select Attachments

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AETNA BETTER HEALTH® OF IOWA

Appendix A

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2.2.1 Subcontractor Qualifications and Agreements

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Administrative Services Agreement

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ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement (together with any exhibits and attachments attached hereto, this "Agreement") is dated as of _____, between Aetna Medicaid Administrators LLC ("Subcontractor"), and Aetna Better Health of Iowa Inc., a Iowa corporation ("Purchaser" or "Company"), and shall become effective on the Effective Date (as defined below).

WHEREAS, Purchaser is a licensed health maintenance organization ("HMO") in the State of Iowa; and

WHEREAS, Purchaser has entered into the State Contract (as defined below); and

WHEREAS, Subcontractor has the experience, trained personnel, knowledge, technical know-how, proprietary information and other resources and capability to develop, operate and market Purchaser's HMO Medicaid business; and

WHEREAS, to negotiate, arrange and administer the Services (as described below), Subcontractor makes use of important intangible property for the benefit of Purchaser.

NOW, THEREFORE, the parties hereto, intending to be legally bound, agree as follows:

1. Definitions. As used in this Agreement, the following terms have the respective meanings assigned to them in this Section 1:

"AAA" means the American Arbitration Association.

"Administrative Fees", for any period, means the product of (a) the Administrative Rate for such period and (b) the Premium Revenue Earned by Purchaser with respect to such period. Administrative Fees include without limitation broker and agent fees and commissions, if any. Administrative Fees exclude bad debt expenses, premium taxes (if any), state and/or guaranty fund assessments, statutory audit fees and expenses, intercompany interest expense, all taxes that are based on Purchaser's income, outside counsel fees and settlements and judgments.

"Administrative Rate" means the percentage rate to be mutually agreed to in writing by Purchaser and Subcontractor upon execution of a Rate Addendum in the form attached hereto as Attachment D.

"Administrative Services" has the meaning assigned to it in Section 2(a).

"Affiliate" means, with respect to any legal entity, any other legal entity or natural person that controls, is controlled by or is under common control with that legal entity.

"C.F.R." means the Code of Federal Regulations.

"Designated Record Set" has the meaning assigned to such term in 45 C.F.R. 164.501.

"Effective Date" means the earliest date which Purchaser is obligated to provide services for the benefit of the Members under the State Contract. This Agreement shall become effective no earlier than when the Purchaser's agreement with the State takes effect.

"HHS" means the United States Department of Health and Human Services.

"Individual" shall have the same meaning as the term "individual" in 45 C.F.R. 164.501 and shall include a person who qualifies as personal representative in accordance with 45 C.F.R. 164.502(g).

"Investments" means debt securities, certificates of deposit, U.S. Treasury obligations and/or other investment vehicles that Purchaser is permitted to purchase under applicable law.

"Members" means subscribers and their dependents covered under the program issued, administered or serviced by Purchaser and/or one or more of Purchaser's affiliates under the State Contract awarded to Purchaser pursuant to the State of Iowa Department of Human Services Request for Proposal for Iowa High Quality Healthcare Initiative RFP MED-16-009.

"Plan" means the health plan administered by Purchaser or its affiliate.

"Privacy Rules" means the regulations at 45 C.F.R. Parts 160-64, implementing the privacy requirements set forth in the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996.

"Protected Health Information" shall have the same meaning as the term "Protected Health Information", as defined by 45 C.F.R. 160.103, limited to the information created or received by Subcontractor from or on behalf of Purchaser.

"Providers" means hospitals, physicians, dentists, pharmacies and other health care providers.

"Rebate" means payments from pharmaceutical manufacturers, the amount of which is based upon utilization of pharmaceutical products, if any, by Members of Purchaser.

"Rebate Services" has the meaning assigned to it in Section 3.

"Required By Law" shall have the same meaning as the term "required by law" in 45 C.F.R. 164.501.

"Revenue Earned", for any period, means, with respect to any legal entity and any period, gross premium revenue earned by such entity during such period on Medicaid sponsored or subsidized business, before ceded premium revenue incurred by such entity during such period, each as determined pursuant to statutory accounting principles and/or practices prescribed or permitted by the State of Iowa.

"Rules" means the AAA's Commercial Arbitration Rules as in effect on January 1, 2013.

"Secretary" shall mean the Secretary of HHS or his or her designee.

"Services" means Administrative Services and/or Rebate Services, if any.

"State" means state of Iowa.

"State Contract" shall mean one or more contracts between the State of Iowa Department of Human Services, pursuant to which Purchaser offers a Medicaid managed care program, including without limitation any contract awarded to Purchaser pursuant to the State of Iowa Department of Human Services Request for Proposal for Iowa High Quality Healthcare Initiative RFP MED-16-009.

2. Administrative Services.

(a) Subcontractor will provide Purchaser with the administrative services and resources specified in Attachment A (collectively "Administrative Services") for the fees set forth in Attachment B.

(b) In addition to Administrative Fees, Purchaser shall reimburse Subcontractor for all out of pocket expenses incurred by Subcontractor or its affiliates on behalf of Purchaser pursuant to this Agreement. Such out of pocket expenses shall include without limitation premium taxes, taxes that are based on Purchaser's income, statutory audit fees and expenses, debt collection costs, state and/or guaranty fund assessments, outside counsel fees and settlements and judgments payable by Purchaser.

(c) Purchaser shall be responsible for any sales, use, value-added or other similar taxes, federal, state or otherwise, that may be levied on the Administrative Services.

(d) If the performance of all or any part of the Services to be provided under this Agreement is delayed or interrupted by a governmental authority or any entity other than Purchaser or Subcontractor, amounts payable under this Agreement will be adjusted as agreed by the parties to reflect any increase in the cost of performance of this Agreement caused by the delay or interruption. Any delivery and performance dates and any other terms or conditions of this Agreement affected by such delay or interruption also will be adjusted by mutual agreement of Subcontractor and Purchaser. If such delay or interruption results in the termination of this Agreement by Purchaser, Subcontractor shall receive an amount equal to six (6) months of Administrative Fees (calculated pursuant to Attachment B based on the calendar month immediately preceding the delay or interruption), all implementation costs and other reasonable charges or expenses. Notwithstanding any other provision of this paragraph, no adjustment will be made for any delay or interruption to the extent that performance of all or any part of the Services to be provided under this Agreement would have been delayed or interrupted by any other cause, including the fault or negligence of Subcontractor. Throughout the period of any delay or interruption of all or any part of the Services to be provided under this Agreement, Purchaser will continue to pay to Subcontractor the Administrative Fees.

3. Rebate Services: If required by the terms of the State Contract, Subcontractor shall provide the Purchaser with the following services (the "Rebate Services"), as necessary and subject to applicable law and the terms of the State Contract, for the fees set forth in Attachment C:

(a) Subcontractor will develop, negotiate and contract, as necessary, for any Rebates and similar arrangements with any pharmaceutical manufacturers and/or pharmaceutical benefits managers (each, a "PBM") relating to the utilization of pharmaceutical products by Members of Purchaser. Subcontractor makes no representation or warranty as to the total amount of any Rebates offered by or received from any particular PBM or by all contracted PBMs in the aggregate.

(b) Subcontractor will manage all aspects of any such Rebate arrangements with PBMs and administer such arrangements. The Rebate Services, if any, shall include as necessary, without limitation, collecting the data necessary for obtaining the Rebates; processing that data and periodically submitting it in a non-Member specific format to the applicable PBMs. The Rebate Services, if any, also may include without limitation the collection by Subcontractor of all Rebate amounts payable under the various PBMs' Rebate arrangements that Subcontractor has established. Subcontractor shall remit to Purchaser all such Rebates generated by Purchaser's Members' utilization of pharmaceutical products within forty-five (45) calendar days after the end of the calendar quarter during which Subcontractor earns such Rebates.

(c) Subcontractor shall develop, implement, maintain and support, as necessary, a formulary strategy for the Plan.

(d) Subcontractor shall develop and maintain as necessary software systems to administer and increase the efficiency of the administration of any PBMs' rebate arrangements. Subcontractor will manage and fund the implementation of such systems. Subcontractor shall be responsible for the maintenance and updates associated with such systems.

(e) Purchaser shall be responsible for any sales, use, value-added or other similar taxes, federal, state or otherwise, that may be levied on such Rebate Services.

(e) The Subcontractor shall maintain appropriate licensure and certifications required in order to perform its obligations under this Agreement.

3. Term and Termination.

(a) The initial term of this Agreement shall be for a period of [___] year(s) commencing on the Effective Date. The term of this Agreement automatically shall be extended for additional periods of one year, unless either party shall notify the other party in writing at least ninety (90) days prior to the expiration of the term then in effect.

(b) This Agreement may be terminated prior to the end of the term then in effect by a written agreement executed by both parties. This Agreement also may be terminated at any time by Subcontractor upon Purchaser's breach of any of Purchaser's obligations under this Agreement or the State Contract following ninety (90) calendar days' prior written notice of such breach and Purchaser's failure to cure such breach within such ninety (90) calendar days. This Agreement also may be terminated at any time by Purchaser upon Subcontractor's breach of any of Subcontractor's obligations under this Agreement following ninety (90) calendar days' prior written notice of such breach and Subcontractor's failure to cure such breach within such ninety (90) calendar days. This Agreement also will be terminated automatically upon the expiration, withdrawal, or termination of the State Contract.

(c) If at any time Subcontractor ceases to be an affiliate of Purchaser, this Agreement may be terminated by either party upon ninety (90) calendar days prior written notice without further liability, except for the payment of all amounts earned or otherwise due under this Agreement with respect to periods ending on or before the effective date of such termination.

(d) The parties mutually agree that it is essential for Protected Health Information to be maintained after the expiration of this Agreement for regulatory and other business reasons. The parties further agree that it would not be feasible for Purchaser to maintain such records because Purchaser lacks the necessary systems and expertise. Accordingly, Purchaser hereby appoints Subcontractor as Purchaser's custodian for the safe keeping of any record containing Protected Health Information that Subcontractor may determine it is appropriate to retain. Notwithstanding the expiration or termination of this Agreement, Subcontractor shall extend the protections of this Agreement to such Protected Health Information, and limit further use or disclosure of such Protected Health Information to those purposes that make the return or destruction of the Protected Health Information not feasible.

(e) Purchaser's Obligations. From time to time, Subcontractor may recommend to Purchaser policies and procedures for the operation of Purchaser's business. Purchaser shall consider implementation of such recommendations and shall review, comment upon and approve or provide notice of any objection to such policies and procedures, unless prohibited or restricted by applicable law or regulation. Purchaser acknowledges and agrees that time is of the essence in the review and approval of such policies and

procedures and that it will dedicate such staff as necessary to meet Subcontractor's time frames.

(b) Purchaser shall cooperate with Subcontractor in the development and negotiation of any Rebate arrangements and provide Subcontractor with such data as may be reasonably necessary for Subcontractor to perform any Rebate Services.

Purchaser hereby appoints Subcontractor as its agent to act on behalf of Purchaser in connection with the Services. As Purchaser's agent, Subcontractor is hereby authorized by Purchaser, among other things, to hire employees and to negotiate and enter into agreements and contracts on behalf of Purchaser. Purchaser shall perform its obligations with respect to, and be responsible for, all such employees and agreements. Nothing in this Agreement shall be construed to transfer or divest any obligation or responsibility of Purchaser which transfer or divestiture is prohibited by law or regulation.

(i) Prohibition Against Assignment and Delegation. Neither Subcontractor nor Purchaser may assign this Agreement or its rights hereunder or delegate or subcontract any of its duties hereunder without the express prior written consent of the other party. Any attempted assignment or delegation in violation hereof shall be null, void and ineffective. Notwithstanding the foregoing, Subcontractor may perform the Services directly or indirectly through one or more of its affiliates or independent contractors, provided Subcontractor shall remain liable to Purchaser for the discharge of Subcontractor's obligations hereunder. Purchaser is responsible for the fulfillment of its obligations under the State Contract. This Agreement shall in no way be construed as a guaranty by Subcontractor with respect to Purchaser's performance of any of Purchaser's obligations under the State Contract.

(ii) Confidentiality of Data and Systems. During the term of this Agreement, each party will receive and have access to proprietary data and systems of the other party. Unless otherwise approved by the other party or unless otherwise required by law, each party agrees (i) to keep all such data and systems confidential and not to disclose or reveal any such data or system to any persons or entities, and (ii) not to use such data or systems for any purpose other than as required to perform Services pursuant to this Agreement. Each party also acknowledges that the other party is the owner of all such data and systems and agrees that they constitute confidential and trade secret information which the recipient will treat as such and will provide security for and take reasonable measures to insure their protection. Upon termination of this Agreement, each party will return all copies of the other party's material in its possession or control or will destroy them, as requested by the other party. The owner of the material will bear reasonable costs for the return or destruction of its material.

(iii) Indemnification. Each party agrees to indemnify and hold the other harmless from and against any and all claims, actions, liabilities, losses, damages, costs and expenses (including without limitation reasonable attorneys' fees) incurred by reason of any legal or administrative action arising out of or caused by the negligence or other culpable wrongdoing of the indemnifying party or by any breach of the indemnifying party's obligations hereunder. Such indemnification is contingent upon prompt notice from the party seeking to be indemnified of the existence of any such claim or action and such party's full cooperation with the

defense of any such claim or action, which shall be controlled by the indemnifying party at its election. The indemnifying party shall, at its election, also have full control over any settlement.

(iv) Obligations and Activities of Subcontractor Regarding Protected Health Information. Subcontractor agrees not to use or further disclose Protected Health Information other than as permitted or required by this Agreement or as Required By Law. Business Associate shall also comply with any further limitations on uses and disclosures agreed by Covered Entity in accordance with 45 C.F.R. 164.522 provided that such agreed upon limitations have been communicated to Business Associate.

Subcontractor agrees to use appropriate safeguards to prevent use or disclosure of Protected Health Information other than as provided for by this Agreement, including but not limited to the safeguards described in this Agreement. Subcontractor agrees to mitigate, to the extent practicable, any harmful effect that is known to Subcontractor of a use or disclosure of Protected Health Information by Subcontractor in violation of this Agreement. Subcontractor agrees to promptly report to Purchaser any use or disclosure of Protected Health Information not permitted by this Agreement of which Subcontractor becomes aware.

Subcontractor agrees to report to Purchaser any Breach of Unsecured Protected Health Information without unreasonable delay and in no case later than five (5) calendar days after Discovery of a Breach. Subcontractor's notification of a Breach under this section shall comply in all respects with each applicable provision of Section 13400 of Subtitle D (Privacy) of ARRA, 45 CFR 164.410, and related guidance issued by the Secretary from time to time.

Subcontractor agrees to ensure that any subcontractors that create, receive, maintain, or transmit Protected Health Information on behalf of Subcontractor agree in writing to the same restrictions and conditions that apply through this Agreement to Subcontractor with respect to such information. In no event shall Subcontractor, without Purchaser's prior written approval, provide Protected Health to any employee or agent, including a subcontractor, if such employee, agent or subcontractor receives, processes or otherwise has access to the Protected Health Information outside of the United States.

Subcontractor agrees to provide access, at the request of Purchaser, and in the time and manner designated by Purchaser, to Protected Health Information in a Designated Record Set, to Purchaser or, as directed by Purchaser, to an Individual in order to meet the requirements of 45 C.F.R. 164.524.Subcontractor agrees to make any amendments to Protected Health Information in a Designated Record Set that Purchaser directs or agrees to pursuant to 45 C.F.R. 164.526 at the request of Purchaser or an Individual, and in the time and manner designated by Purchaser.

Subcontractor agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Subcontractor on behalf of, Purchaser available to the Secretary, in a time and

manner designated by the Secretary, for purposes of the Secretary determining Purchaser's compliance with the Privacy Rule.

Subcontractor agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Purchaser to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. 164.528.Subcontractor agrees to provide to Purchaser the information collected in accordance with this Section 8 to permit Purchaser to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. 164.528.

Subcontractor agrees that it shall request from Purchaser and so disclose to its affiliates, agents and subcontractors or other third parties, (i) the information contained in a "limited data set," as such term is defined at 45 C.F.R. 164.514(e)(2), or, (ii) if needed by Subcontractor, the minimum necessary to accomplish the intended purpose of such requests or disclosures.

With respect to Electronic Protected Health Information, Subcontractor shall implement and comply with (and ensure that its subcontractors implement and comply with) the administrative safeguards set forth at 45 C.F.R. 164.308, the physical safeguards set forth at 45 C.F.R. 310, the technical safeguards set forth at 45 C.F.R. 164.312, and the policies and procedures set forth at 45 C.F.R. 164.316 to reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of Purchaser. Subcontractor acknowledges that, (i) the foregoing safeguard, policies and procedures requirements shall apply to Subcontractor in the same manner that such requirements apply to Purchaser.

With respect to Electronic Protected Health Information, Subcontractor shall ensure that any subcontractors that create, receive, maintain, or transmit Electronic Protected Health Information on behalf of Subcontractor, agree to comply with the applicable requirements of Subpart C of 45 C.F.R. Part 164 by entering into a contract that complies with 45 C.F.R. Section 164.314.

Subcontractor shall report to Purchaser any Security Incident of which it becomes aware, including Breaches of Unsecured Protected Health Information as required by 45 C.F.R. Section 164.410.

If Subcontractor conducts any Standard Transactions on behalf of Purchaser, Subcontractor shall comply with the applicable requirements of 45 C.F.R. Parts 160-162.

To the extent Subcontractor is to carry out one or more of Purchaser's obligation(s) under Subpart E of 45 CFR Part 164, Subcontractor shall comply with the requirements of Subpart E that apply to Purchaser in the performance of such obligation(s).

Subcontractor shall use commercially reasonable efforts to maintain the security of Protected Health Information and to prevent unauthorized uses or disclosures of Protected Health Information.

(v) General Use and Disclosure. Except as otherwise limited in this Agreement, Subcontractor shall not de-identify any or disclose Protected Health Information except as authorized by Purchaser to perform Subcontractor's obligations under this Agreement, provided that such use or disclosure would not violate (i) the Privacy Rule if done by Purchaser or (ii) the minimum necessary policies and procedures of Purchaser.

(vi) Specific Use and Disclosure Provisions. Except as otherwise limited by this Agreement, Subcontractor may use Protected Health Information for the proper management and administration of Subcontractor or to carry out the legal responsibilities of Subcontractor. Except as otherwise limited by this Agreement, Subcontractor may disclose Protected Health Information for the proper management and administration of Subcontractor, provided that disclosures are Required By Law, or Subcontractor obtains reasonable assurances from the person to whom the information is disclosed that the information disclosed will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies Subcontractor of any instances of which such person is aware in which the confidentiality of the information has been breached in accordance with the Breach and Security notifications requirements of this Agreement.

Subcontractor shall not directly or indirectly receive remuneration in exchange for any Protected Health Information of an Individual without Purchaser's prior written approval and notice from Purchaser that it has obtained from the Individual, in accordance with 45 C.F.R. 164.508, a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by Subcontractor. The foregoing shall not apply to Purchaser's payments to Subcontractor for services delivered by Subcontractor to Purchaser.

Except as otherwise limited in this Agreement, Subcontractor may use Protected Health Information to provide Data Aggregation services to Purchaser as permitted by 45 C.F.R. 164.504(e)(2)(i)(B).Subcontractor may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. 164.502(j)(1).

(vii) Certain Obligations of Purchaser Regarding Protected Health Information. Provisions for Purchaser to Inform Subcontractor of Privacy Practices and Restrictions. Purchaser shall notify Subcontractor of any limitation(s) in its notice of privacy practices of Purchaser in accordance with 45 C.F.R. 164.520, to the extent that such limitation(s) may affect Subcontractor's use or disclosure of Protected Health Information. Purchaser shall provide Subcontractor with any change in, or revocation of, permission by any Individual to use or disclose Protected Health Information, to the extent that such change and/or revocation affects Subcontractor's uses and/or disclosures of Protected Health Information. Purchaser shall notify Subcontractor of any restriction to the use or disclosure of that Purchaser has agreed to in accordance with 45 C.F.R. 164.522. to the extent

that such restriction may affect Subcontractor's use or disclosure of Protected Health Information.

(f) Permissible Requests by Purchaser. Purchaser shall not request Subcontractor to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy or Security Rules if done by Purchaser.

(g) Miscellaneous. Regulatory References. A reference in this Agreement to a section in the Privacy Rules means the section as in effect or as amended, and for which compliance is required. Terms not defined hereunder shall have the meanings assigned to such terms under the Privacy and Security Rules.

(h) Amendments. Except as set forth below in this Section 12(b), this Agreement may be amended solely by written agreement of the parties hereto, subject to any required government approvals. Upon the enactment of any law or regulation affecting the use or disclosure of Protected Health Information, or the publication of any decision of a court of the United States or any state relating to any such law or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, either party may, by written notice to the other party, amend this Agreement in such manner as such party determines necessary to comply with such law or regulation. If the other party disagrees with such amendment, it shall so notify the first party in writing within thirty (30) calendar days of the notice. If the parties are unable to agree on an amendment within thirty (30) calendar days thereafter, then either of the parties may terminate this Agreement on thirty (30) calendar days written notice to the other party.

(i) Survival. The respective rights and obligations of Subcontractor under Section 4(d) of this Agreement shall survive the termination of this Agreement.

(j) Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Purchaser to comply with the Privacy Rules.

(k) No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and the respective successors and permitted assigns of the parties, any rights, remedies, obligations, or liabilities whatsoever.

(l) Notices. Any notice required to be given pursuant to this Agreement shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid, or by email or facsimile:

to Subcontractor at:

Aetna Better Health of Iowa Inc.
Law & Regulatory Affairs, RE6A
151 Farmington Avenue
Hartford, CT 06156
P: 860-273-2810
F: 860-902-7738
Attention: Legal Department

and to Purchaser at:

Aetna Medicaid Administrators LLC
Law & Regulatory Affairs, RE6A
151 Farmington Avenue
Hartford, CT 06156
P: 860-273-2810
F: 860-902-7738
Attention: Legal Department

The above addresses may be changed at any time by either party upon written notice.

(m) Waiver. No waiver of any term or provision of this Agreement shall be valid unless in writing and executed by the waiving party. It is expressly understood that if any party shall fail to perform any term or condition of this Agreement and the other shall not enforce or give notice of default, the failure to enforce or give notice of default shall not prevent enforcement of any other term or condition of this Agreement or the giving of notice of any other failure to perform or any other default.

(n) Integration. This Agreement, including the attachments hereto, constitutes the entire agreement between the parties with respect to the subject matter hereof.

(o) No Violation of Law. This Agreement shall not be interpreted to impose obligations or responsibilities upon a Subcontractor which require the Subcontractor to violate the statutes or rules governing licensure of the Subcontractor if the Subcontractor is to comply with the terms of this Agreement.

(p) Validity of Agreement/Choice of Law. The validity, enforceability and interpretation of this Agreement will be determined and governed by the laws of the State of Iowa without regard for the conflicts of laws principles thereof. The invalidity or unenforceability of any term or provision hereof will not, unless otherwise specified herein, affect the validity or enforceability of any other term or provision hereof.

(q) Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original, and all of which, together, constitute one and the same instrument. This Agreement shall become binding when one or more counterparts, individually or taken together, bears the signature of both parties.

(r) Headings for Convenience. The underlined headings contained in this Agreement are for convenience of reference only and are not part of this Agreement.

(s) Arbitration. Any controversy or claim arising out of or relating to this Agreement or the breach, termination, or validity of this Agreement, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration administered by the AAA and conducted by a sole arbitrator, who shall be unaffiliated with each party, in accordance with the Rules. The arbitration shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16, to the exclusion of state laws inconsistent therewith or that would produce a different result, and judgment on the award rendered by the arbitrator may be entered by any court having jurisdiction thereof. Except as may be required by law or to the extent necessary in connection with a judicial challenge, or enforcement of an award, neither a party nor the arbitrator may disclose the

existence, content, record or results of an arbitration. Fourteen (14) calendar days before the hearing, the parties will exchange and provide to the arbitrator (i) a list of witnesses they intend to call (including any experts) with a short description of the anticipated direct testimony of each witness and an estimate of the length thereof, and (ii) premarked copies of all exhibits they intend to use at the hearing. Depositions for discovery purposes shall not be permitted. The arbitrator may award only monetary relief and is not empowered to award damages other than compensatory damages. The location of the arbitration shall be in Iowa or any other location acceptable to both parties.

(t) Management of Purchaser. Notwithstanding any other provision of this Agreement, it is understood that the business and affairs of Purchaser shall be managed by its Board of Directors and, to the extent delegated by such Board and applicable law, by Purchaser's officers. Neither Subcontractor nor any of its officers or agents shall have any management authority or prerogatives with respect to the business affairs and/or operations of Purchaser except as specifically set forth in this Agreement.

(u) Non-Discrimination. All services provided pursuant to this Agreement shall be provided without regard to the Member's race, color, sex, age, religion, national origin or source of payment.

(v) Independent Contractors. The relationship of Subcontractor to Purchaser, as well as Subcontractor's employees and agents, is that of independent contractors, and except as expressly provided herein to the contrary, Subcontractor shall not be considered an agent or representative of Purchaser for any purpose, nor shall Subcontractor hold itself out to be an agent or representative of Purchaser for any purpose.

(w) Reports. Records and Audits. The books and records of Purchaser as they pertain directly to this Agreement will be available for review and audit by the State of Iowa Department of Human Services and any other governmental authority with jurisdiction over the State Contract (collectively, the "Governmental Authority"). To the extent required by law and to the extent consistent with the appropriate jurisdiction of the Governmental Authority, the books and records of Subcontractor as they pertain directly to this Agreement will be available for review in the State of Iowa.

(x) Subcontractor Regulatory Addendum. The parties shall comply with the terms and conditions set forth in Section 25 of the RFP, or other provisions required by the State Contract, as applicable.

(y) Severability. Any determination that any provision of this Agreement or any application thereof is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Neither party shall assert or claim that this Agreement or any provision hereof is void or voidable if such party performs under this Agreement without prompt and timely written objection.

THE NEXT PAGE IS THE SIGNATURE PAGE

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date and year first set forth above.

AETNA MEDICAID ADMINISTRATORS LLC, an Arizona limited liability company

By:_____
Name:_____
Title:_____
Date:_____

AETNA BETTER HEALTH OF IOWA INC., a Iowa corporation

By:_____
Name:_____
Title:_____
Date:_____

ATTACHMENT A
ADMINISTRATIVE SERVICES

Specific Responsibilities and Services. As agreed to between Purchaser and Subcontractor from time to time, Subcontractor's duties may include without limitation the following, as necessary and subject to applicable law and the terms of the State Contract:

(a) Finance. The following finance functions related to Purchaser's business to the fullest extent permitted by applicable law: All accounting and reporting functions, including without limitation billing, accounts receivable, accounts payable, payroll, budgets, premium rates, financial and statutory reporting, tax return preparation and cash management. All financial records shall be available to Purchaser at all times. As more fully set forth in Section (u) of this Attachment A, Subcontractor shall deposit in a bank (or banks) all receipts and monies arising from the operation of Purchaser and make disbursements on behalf of Purchaser in such amounts and at such times as the same are required. Signatures and approvals as to the amounts of all checks shall be in accordance with duly adopted policies of Purchaser. Subcontractor shall supervise and direct the collection of all accounts receivable due to Purchaser, taking all commercially reasonable steps to minimize the number and amount of bad debts.

(b) Human Resources. Human resource and personnel administrative and recruiting services. Purchaser (through its Board of Directors in the case of officers) shall have the right to approve the hiring, termination or disciplining of any officer, department head or medical director of Purchaser.

(c) Operational Services. General operational services, including without limitation telephone and computer system design services, mail services and microfilm services.

(d) Procurement. Procurement services, including without limitation the extension of Subcontractor's volume vendor discounts, to the extent available.

(e) Legal Services. Subject to the direction of Purchaser's Board of Directors, Subcontractor shall arrange for provision of the legal services necessary to meet the needs of Purchaser except with respect to any to any legal dispute between Subcontractor and Purchaser relating to this Agreement. Without limiting the generality of the foregoing, (i) Subcontractor shall arrange for the legal review and analysis of enrollee, benefit, Provider, and marketing contracts, regulatory compliance matters, management and coordination of Purchaser's litigation, arbitration, and subrogation activities, and general corporate and healthcare related legal work; and (ii) Subcontractor shall coordinate the defense of any litigation or claims related to the Services or Purchaser's operations, although Purchaser shall remain liable for any ultimate settlements or judgments, as set forth in Section 2(b).

(f) Claims Payment. Payment of claims and benefits incurred by Members.

(g) Quality Assessment/Utilization Review/Disease Management/ Patient Management/Case Management. Medical support functions in the nature of quality assessment services, including without limitation the preparation of quality assessment services, practice guidelines, National Committee for Quality Assurance ("NCQA") accreditation, disease management services, utilization review services, patient management and case management services, and risk

management programs, and Member grievance policies and procedures to enable Member access to cost effective health care.

(h) Customer Services. Employer and Member customer services, including without limitation new Member telephone calls, Member surveys, servicing Member inquiries and problems and Member enrollment.

(i) Provider Network Services. Support functions in the nature of Provider contracting services, including without limitation the service obligations and quality aspects of agreements with Providers and Provider relations services. In addition, Subcontractor hereby makes available to Purchaser, and grants Purchaser access to, as necessary or desirable, any Subcontractor Provider network (including without limitation contracts that Subcontractor negotiates with national and regional vendors and providers, contracts that Subcontractor negotiates with centers of excellence outside of Purchaser's service area, and those portions of Subcontractor's Provider network that are made available to Subcontractor by agreements and/or other arrangements between Subcontractor and its affiliates). At Purchaser's request, Subcontractor shall enforce and/or use commercially reasonable efforts to cause its affiliates to enforce their respective agreements with the Providers in Subcontractor's Provider network for the benefit of Purchaser.

(j) Facilities. Negotiating such terms and agreements as may be necessary or advisable for the furnishing of facilities, utilities, services, concessions and supplies for the maintenance and operation of Purchaser.

(k) Marketing. Subcontractor shall produce advertising, public relations and marketing materials on behalf of Purchaser for distribution by Purchaser and/or by Purchaser's duly licensed agents and shall support Purchaser in its marketing efforts. Purchaser acknowledges that any solicitation documents used by Purchaser are subject to filing with, and approval by, state regulatory agencies. Subcontractor also shall produce website marketing and other internet services and materials for Purchaser.

(l) Insurance and Risk Management. Subcontractor shall negotiate and maintain general and professional liability insurance, naming Purchaser as an additional insured thereunder, in amounts reasonably acceptable to Purchaser. Subcontractor shall deliver memorandum copies of its insurance certificates to Purchaser upon request.

(m) Data Processing. The computer and MIS resources necessary to perform the Services. Subcontractor shall provide access to adequate management information systems to carry out this Agreement.

(n) Pharmacy Services. Subcontractor may provide Purchaser with pharmacy benefit management services under Subcontractor's pharmacy benefit management program, including without limitation the following:

- Direct reimbursement of pharmacy claims to pharmacy Providers;
- Sales, marketing and account support services;
- Customer and provider services;
- Development and operation of a pharmacy precertification unit;
- Development and supply of management reports;

- Performance of drug utilization review programs, quality management programs and audit programs;
- Development and operation of a Pharmacy and Therapeutics Committee;
- Development, installation and implementation of a medication formulary;
- Management of Purchaser's pharmacy Provider network; and
- Provision of such other pharmacy-related benefit program management services as may be agreed upon by the parties from time to time.

(o) Ancillary and Other Agreements. Subcontractor shall negotiate and enter into such ancillary agreements on behalf of Purchaser as Subcontractor may deem necessary or advisable for the maintenance and operation of Purchaser.

(p) Licenses and Permits. Subcontractor shall apply for and maintain on behalf of Purchaser all necessary licenses and permits required by the State of Iowa, or by any other regulatory body with jurisdiction over Purchaser.

(q) Benefit Contracts. Subcontractor shall prepare the agreements and other documents relating to the Plan, as applicable, including without limitation coverage documents reflecting the benefit to be provided by Purchaser.

(r) Fees and Expenses. Subcontractor shall pay all fees and expenses of actuarial, auditing and/or accounting consultants of any type retained by Subcontractor to perform the Services, including without limitation any consultant used to obtain federal qualification or competitive medical plan status. Such fees and expenses are included in the Administrative Fees.

(s) Agents Fees and Commissions. On behalf of Purchaser, Subcontractor and/or its affiliates shall pay all broker and agent fees and/or commissions due with respect to Purchaser's business placed by such brokers and/or agents, if any. As set forth in Section 2(a), such fees and commissions (if any) are included in the Administrative Fees.

(t) Out-of-Pocket Corporate Maintenance Expenses. On behalf of Purchaser, Subcontractor and/or its affiliates shall pay the following out of pocket corporate maintenance expenses of Purchaser: costs of periodic state or federal securities or corporate reports, amendments to corporate documents, any expenses for fees of Purchaser's Board of Directors, and costs associated with meetings of the Board of Directors or shareholders or committee meetings. Such expenses are included in the Administrative Fees.

(u) Cash Management Services. Purchaser shall participate in Subcontractor's centralized cash management system (the "System"), and Subcontractor shall administer the System in accordance with the terms and conditions set forth below:

1. Procedures. The procedures for the System are as follows:

   a. All claims, expenses and other disbursement requests submitted for payment by Purchaser shall be processed and paid by Subcontractor through a centralized disbursement account or accounts held as specified herein.

b. All premiums (if any) and other payments made to Purchaser by third parties shall be received and processed by Subcontractor through a centralized depository account or accounts (e.g., lock box(es)) held as specified herein.

c. All of the foregoing transactions shall be recorded on the books of Purchaser in an intercompany account with Subcontractor and recorded on the books of Subcontractor in an intercompany account with Purchaser.

d. The System also shall account for the reimbursement by Purchaser to Subcontractor of costs expended by Subcontractor and/or its affiliates on behalf of Purchaser using applicable statutory accounting principles and/or practices prescribed or permitted by the State of Iowa and/or accounting principles generally accepted in the United States of America.

e. Subcontractor shall follow such directions and instructions as may be given to Subcontractor by Purchaser from time to time with respect to the funds of Purchaser and the participation of Purchaser in the System.

2. Condition of Participation. The participation of Purchaser in the System, as described in this Agreement, is expressly conditioned upon all investment accounts holding assets of Purchaser being in the name of Purchaser. Depository, disbursement and other non-investment accounts holding assets of Purchaser may be in the name of Purchaser and/or Subcontractor.

3. Settlement of Accounts. Intercompany balances resulting from the operation of the System shall be settled as to Purchaser within 15 calendar days after the end of each calendar month (where possible) and in no event more than 45 calendar days after the end of each calendar quarter.

4. Interest on Balances. Interest shall be charged or credited monthly on all intercompany cash balances resulting from the operation of the System as set forth in Section (b) of Attachment B.

(v) Investments. Subcontractor may, from time to time, buy Investments for Purchaser and place such Investments in the name of or for the account of Purchaser for the purpose of settling intercompany balances. Such Investments shall be held in the name of Purchaser. Unless specifically permitted by an investment policy by Purchaser's Board of Directors, Subcontractor shall not place the funds of Purchaser in any Investment that is not secured or backed by the full faith and credit of the United States or insured by a U.S. Government agency (e.g., the FDIC).

(w) Audit Rights. Purchaser shall have the right, at its expense, to audit the books, records and accounts of Subcontractor related to this Agreement after giving reasonable notice to Subcontractor of Purchaser's intent to conduct such an audit. In the event of such audit, Subcontractor shall give Purchaser reasonable cooperation and access to all books, records and accounts necessary to the audit.

(x) Records. Each party shall be the sole owner of its financial and accounting records, regardless of the use or possession by a party of any other party's records. Subcontractor and Purchaser shall each individually maintain separate books, accounts and records with respect to Services provided under this Agreement. The books and records of Purchaser shall be maintained at such location or locations, within or without the State of Iowa, as Subcontractor and Purchaser may

agree from time to time. Subcontractor and Purchaser each shall maintain their own books, accounts and records in such a way as to disclose clearly and accurately the nature and detail of the transactions between them.

(y) Reports. Subcontractor shall submit to Purchaser such reports regarding the Services at such times as Purchaser shall reasonably request or as Subcontractor shall deem necessary or appropriate to keep Purchaser apprised of Subcontractor's performance of the Services.

(z) Additional Notices. Subcontractor shall promptly notify Purchaser upon (i) receipt of any summons, complaint or process before any legal or regulatory body relating to this Agreement or (ii) obtaining knowledge of any legal or administrative claim, action, investigation or proceeding against Subcontractor relating to this agreement.

ATTACHMENT B
FEES FOR ADMINISTRATIVE SERVICES

(a) For the Administrative Services, Purchaser shall pay Subcontractor the Administrative Fees within forty-five (45) calendar days after the end of the calendar quarter with respect to which such Administrative Fees are payable.

(b) Except as set forth on Attachment C, all intercompany balances under this Agreement shall be settled within forty-five (45) calendar days after the end of each calendar quarter. Interest shall be charged monthly on all intercompany balances (including without limitation Administrative Fees and cash balances resulting from the operation of the System) at a rate equal to the monthly average overnight interest rate earned on Subcontractor's investments during the month for which interest on such intercompany balances is being calculated.

(c) Each of Subcontractor and Purchaser shall have the right to offset all intercompany receivable and payable balances (including without limitation Administrative Fees) with the other party.

(d) The Administrative Fees are based upon the current federal and state laws and regulations that govern Subcontractor and/or Purchaser. The parties hereto acknowledge that if any of such laws or regulations is amended, the cost and expenses of operating Purchaser may change. Therefore, upon any such amendment or replacement, the parties shall renegotiate in good faith and agree on revised Administrative Fees hereunder.

ATTACHMENT C
REBATE SERVICES

(a) Pursuant to Section 3 of this Agreement, Subcontractor shall collect the Rebate amounts, if any, from the applicable manufacturers and remit 100% of the Rebates to Purchaser.

(c) All Rebate transactions shall be recorded on the books of Purchaser in an intercompany account with Subcontractor and recorded on the books of Subcontractor in an intercompany account with Purchaser.

(d) Intercompany balances for any Rebates shall be settled within forty-five (45) calendar days after the end of the calendar quarter during which Subcontractor earned the Rebates. If Subcontractor fails to forward the correct sum to Purchaser, or Purchaser fails to pay Administrative Fees, within the specified time, the party to whom the payment is due may charge interest at a rate equal to the monthly average overnight interest rate earned on Subcontractor's investments during the period for which interest on such amount is being calculated, along with any costs of collection and reasonable attorneys' fees.

(e) Each of Subcontractor and Purchaser shall have the right to offset all intercompany receivable and payable balances (including without limitation Administrative Fees) with the other party.

(f) Subcontractor shall submit to Purchaser on a quarterly basis a statement with any Rebates collected and remaining Rebate amounts to be forwarded to Purchaser, if any.

(g) The Administrative Fees are based upon the current federal and state laws and regulations that govern Subcontractor and/or Purchaser. The parties hereto acknowledge that if any of such laws or regulations is amended, the cost and expenses of operating Purchaser may change. Therefore, upon any such amendment or replacement, the parties shall renegotiate in good faith and agree on revised Administrative Fees hereunder.

ATTACHMENT D
RATE ADDENDUM

Subcontractor, an Arizona corporation ("Subcontractor"), and Aetna Better Health of Iowa Inc., a Iowa corporation ("Purchaser") hereby agree that the Administrative Rate set forth in the Administrative Services Agreement between Subcontractor and Purchaser (the Agreement) is [_____] percent ([__]%).

AETNA MEDICAID ADMINISTRATORS LLC, an Arizona limited liability company

By:_____
Name:_____
Title:_____
Date:_____

AETNA BETTER HEALTH OF IOWA INC., a Iowa corporation

By:_____
Name:_____
Title:_____
Date:_____

Program Agreement

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PROGRAM AGREEMENT

This Program Agreement (the "Program Agreement") made and entered into between Aetna Medicaid Administrators LLC, an Arizona limited liability company (formerly Schaller Anderson, LLC) ("Company" or "Health Plan") and Aetna Health Management, LLC. ("AHM Affiliate" or "Subcontractor") is effective as of _____. Capitalized terms used and not defined herein shall have the meaning assigned to them in the Amended and Restated Intercompany Master Agreement, effective as of May 1, 2012, between AHM Affiliate and Company, as it may be amended from time to time (the "Master Agreement").

WHEREAS, Company and AHM Affiliate are Affiliates, under common ownership of Aetna Inc. as the ultimate parent; and

WHEREAS, Company has completed a review of AHM Affiliate's Credentialing and Recredentialing Program and has reviewed AHM Affiliate's documentation of same; and

WHEREAS, Company has determined that AHM Affiliate's Credentialing and Recredentialing Program meets Company's requirements and applicable state requirements; and

WHEREAS, Company wishes AHM Affiliate to perform, and AHM Affiliate wishes to perform, certain Credentialing and Recredentialing functions on behalf of Company for the Program (defined below); and

WHEREAS, Company and AHM Affiliate have entered into the Master Agreement, setting forth the Credentialing and Recredentialing functions to be performed by AHM Affiliate for Company (the "Services"); and

NOW, THEREFORE, in consideration of the undertakings of the parties to each other as stated herein the parties agree as follows:

I. Controlling Provisions.
This terms and conditions set forth in the Master Agreement are incorporated into this Program Agreement by reference. Any provisions of the Master Agreement which directly conflict with the terms and provisions of this Program Agreement will be deemed waived as it relates to this Program Agreement and the Program (defined below), unless such conflict may be resolved through construction or amendment as provided herein. In the event of any inconsistency between the terms of this Program Agreement and the Master Agreement, the terms of this Program Agreement shall govern and control as it relates to this Program Agreement and the Program (defined below), and all other terms and provisions of the Master Agreement not affected by this Program Agreement shall remain in full force and effect. Upon the enactment of any law or regulation impacting credentialing or recredentialing services, either party may, by written notice to the other, amend this agreement in such a manner as such party determines necessary to comply with such law or regulation. If the other party disagrees with such amendment, it shall so notify the first party in writing within thirty (30) calendar days of the notice. If the parties are unable to agree on an amendment within thirty (30) calendar days thereafter, then either of the parties may terminate this Program Agreement on thirty (30) calendar days notice.

II. Termination.
This Program Agreement may be terminated: (i) in accordance with the terms of the Master Agreement; (ii) upon the mutual agreement of AHM Affiliate and Company; or (iii) by either party at any time for any reason upon sixty (60) days prior written notice to the other party.

III. Program Participation.

As may be agreed to between the parties hereto from time to time, AHM Affiliate will provide the services described in this Program Agreement, including the Credentialing and Recredentialing functions provided on behalf of Company for Participating Providers who are or who apply to become contracted with Plan or with Company or its affiliate to provide services to Plan Members enrolled with the following programs (the "Program"):

The Medicaid Managed Care Plan offered by Company under one or more State Contracts awarded to Company by State of Iowa Department of Human, including without limitation any contract awarded to Company pursuant to the State of Iowa Department of Human Services Request for Proposal for Iowa High Quality Healthcare Initiative RFP MED-16-009.

All other Iowa Medicaid programs for which Aetna Medicaid Administrators LLC serves as plan administrator.

IV. Credentialing and Recredentialing Services.

AHM Affiliate will provide Credentialing and Recredentialing services for Providers who are or who apply to become Participating Providers as more fully described below.

1. Written policies and procedures. AHM Affiliate will establish and maintain written policies and procedures for the Credentialing and triennial Recredentialing of Providers who apply to become Participating Providers. The policies and procedures will also set forth the scope of the Credentialing and Recredentialing Program (i.e. what categories of Providers are credentialed). Said policies and procedures and any substantive revisions thereto will be subject to the review by and approval of Company.

2. Credentialing committee. AHM Affiliate shall establish or maintain a credentialing committee to make recommendations regarding Credentialing and Recredentialing decisions. Said committee shall include an appropriate number of Providers who are physicians or dentists, as required by state law or regulation.

3. Credentialing and Recredentialing standards. AHM Affiliate shall adopt Credentialing and Recredentialing criteria in accordance with NCQA standards.

4. Application process. AHM Affiliate shall establish or maintain a formal application process as required by state law.

AHM Affiliate shall include an attestation by the applicant to the accuracy and completeness of the information on the credentialing and recredentialing applications.

AHM Affiliate shall promptly report to Company any "adverse action" taken by, or notice of such action received by, AHM Affiliate with respect to the licensure or membership status of any Participating Provider. For purposes of this section, "adverse action" means an action that denies, restricts, encumbers, revokes, suspends, probates, or constitutes a censure or reprimand (whether public or private), the voluntary surrender of licensure or privileges to avoid such action, voluntary payment of fines or consent to other disciplinary actions, and the initiation of any investigation that could result in such action.

5. Querying process. The Credentialing and Recredentialing process shall include obtaining information on the provider from the National Practitioner Data Bank and the applicable state licensing dental board; information to ascertain whether Provider has been the subject of investigation or sanction activity by any governmental health program

including but not limited to Medicare, Medicaid or, if applicable, CHAMPUS; and information concerning any disciplinary action by any licensing agency.

6. Recredentialing. In addition to the requirements stated above, AHM Affiliate shall conduct ongoing triennial recredentialing which includes the standards in Sections 3 through 5 of this Attachment 1 and a review of data from performance indicators as determined by Company.

7. Sanctions, terminations and suspensions. AHM Affiliate shall adopt policies and procedures, which, at a minimum, comply with the requirements of any applicable state peer review law and are acceptable to Company, to reduce, suspend, or terminate the Participating Provider status of a Provider. Such policies and procedures shall include a mechanism for reporting to appropriate authorities, including but not limited to the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank and applicable state regulatory agency, serious quality deficiencies leading to suspension or termination and an appeal process for adversely affected participating Providers. AHM Affiliate shall notify Company of any report submitted pursuant to this section.

V. Governing Law.
This Program Agreement shall be governed in all respects by the laws of the State of New Jersey.

VI. Additional Services.
AHM Affiliate may provide or cause to be provided the following additional services for the benefit of the Program as more fully described below; provided, however, such services shall be performed in accordance with applicable laws and governmental regulations for the appropriate Program:

i. Management of after hours behavioral health calls from providers, as applicable. Such services shall include (i) intake of clinical information and data entry into the QNXT system, and (ii) authorization of requests for patient stays of one day, pending any additional days until full review can be completed during normal business hours. Denials will not be issued as part of these after-hour services.

ii. Radiology benefit management services, which may include patient management and call center management.

iii. Such other services provided or caused to be provided by AHM Affiliate for the benefit of the Program, as agreed upon by the parties from time to time.

VII. Participating Providers.
Notwithstanding any other provision of the Intercompany Master Agreement, for purposes of this Program Agreement "Participating Provider" shall include any psychiatrist, psychologist, physician, dentist, or other individual or entity involved in the delivery of behavioral health care, physical health care and/or dental services, as applicable, who or which has entered into a continues to have a valid and effective Provider Participation Agreement or Individual Provider Addendum with Company.

IN WITNESS WHEREOF, intending to be legally bound, this Master Agreement may be executed in one or more counterparts and after at least one counterpart has been signed by each officer of the respective company.

Aetna Health Management, LLC
By: _____
Printed Name: _____
Title: _____

Aetna Medicaid Administrators LLC
By: _____
Printed Name: _____
Title: _____

Non-Medical Services Provider Agreement

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MEDICAID CONTRACTOR AGREEMENT

TABLE OF CONTENTS

Program Participation Schedule
Services and Compensation Schedule
Contractor Regulatory Compliance Addendum

[Note: To the extent applicable, add the following (and/or other) exhibits.**]**

Provider Regulatory Compliance Addendum
Delegated Claims Addendum
Delegated Credentialing Addendum
Delegated Patient Management Addendum
Delegated Quality Management Addendum
Delegated Customer Service Addendum
[Other]

MEDICAID CONTRACTOR AGREEMENT

This Medicaid Contractor Agreement, together with all exhibits and attachments hereto (collectively, the "Agreement") is made and entered into as of _____ [Identify Effective Date] ("Effective Date") by and between _____[Identify the name of the health plan], a [Identify State] corporation, on behalf of itself and its Affiliates (hereinafter "Company"), and _____ [Identify Contractor] (hereinafter "Contractor"). A **Contractor Regulatory Compliance Addendum** is attached to this Agreement and is binding upon the Parties. In the event of any inconsistent or contrary language between the **Contractor Regulatory Compliance Addendum** and any other part of this Agreement, including, but not limited to, any other exhibits, attachments, schedules or amendments, the provisions of the **Contractor Regulatory Compliance Addendum** shall prevail.

WHEREAS, Company administers Plans for Government Sponsors that provide access to health care services to Members or arranges for the provision of health care services to Members of Government Programs; and

WHEREAS, Company contracts with certain health care providers to provide access to such health care services to Members; and

WHEREAS, Contractor has established a network of service providers ("Contractor Service Providers"), under contract with Contractor, to provide Contractor Services to Members; and

WHEREAS, Company and Contractor mutually desire to enter into an arrangement whereby Contractor, through its Contractor Service Providers, will provide and arrange for the provision of covered Contractor Services (hereinafter, the "Covered Services") to Members; and

[**Note:** To the extent applicable, identify those services delegated to Contractor in the following recital clause.]

WHEREAS, Company shall delegate to Contractor [claims], [credentialing], [patient management], [quality management], [customer service], which duties and obligations of the Parties related to such delegated services are set forth in the [Delegated Claims Addendum], [Delegated Credentialing Addendum], [Delegated Patient Management Addendum], [Delegated Quality Management Addendum], [Delegated Customer Service Addendum] attached hereto and made a part of this Agreement hereof; and

WHEREAS, in return for the provision of Covered Services by Contractor, Company will provide payment to Contractor for Covered Services in accordance with the terms of this Agreement.

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants, promises and undertakings herein, the sufficiency of which is hereby acknowledged, and intending to be legally bound hereby, the parties agree as follows:

1.0 DEFINITIONS

When used in this Agreement, all capitalized terms shall have the following meanings:

1.1 Affiliate. Any corporation, partnership or other legal entity (including any Plan) directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with either party to this Agreement.

1.2 Confidential Information. Any information that identifies a Member and is related to the Member's participation in a Plan, the Member's physical or mental health or condition, the provision of health care to the Member or payment for the provision of health care to the Member. Confidential Information includes, without limitation, "individually identifiable health information," as defined in 45 C.F.R. § 160.103 and "non-public personal information" as defined in laws or regulations promulgated under the Gramm-Leach-Bliley Act of 1999, as applicable. Confidential Information may be referred to as "Member Confidential Information."

1.3 Contractor Services. Services covered by the Plan, certain of which covered services may be identified in the **Services and Compensation Schedule** attached hereto and made a part of this Agreement hereof. Such services shall also be referred to as "Covered Services."

1.4 Contractor Services Providers. A service provider under contract with Contractor to provide Covered Services to Members.

1.5 Copayment. A charge required under a Plan that must be paid by a Member at the time of the provision of Covered Services, or at such other time as determined by Contractor.

1.6 Covered Services. Those Contractor Services provided by Contractor Service Provider for which a Member is entitled to receive coverage under the terms and conditions of a Plan.

1.7 Deductible. An amount that a Member must pay for Covered Services during a specified coverage period in accordance with the Member's Plan before benefits will be paid.

1.8 Effective Date. Defined in first paragraph of this Agreement.

1.9 Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, her pregnancy or health or the health of her fetus) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part; or such other definition as may be required by applicable law.

1.10 Emergency Services. Covered Services furnished by a qualified provider and necessary to evaluate or stabilize an Emergency Medical Condition.

1.11 Government Programs. Plans operated and/or administered by Company pursuant to a State Contract.

1.12 Government Sponsor. A state agency or other governmental entity authorized to offer, issue and/or

administer one or more Plans, and which, to the extent applicable, has contracted with Company to administer all or a portion of such Plan(s).

1.13 Member. An individual covered by or enrolled in a Plan and entitled to such Covered Services offered by the Plan.

1.14 Party. Company or Contractor, as applicable.

1.15 Plan. A Member's health care benefits as set forth in the State Contract. Such Plans are listed in the **Program Participation Schedule** attached hereto and made a part hereof.

1.16 Policies. The policies and procedures promulgated by Company (and, where applicable, Government Sponsor) which relate to the duties and obligations of the Parties under the terms of this Agreement, including, but not limited to: (a) quality improvement/management; (b) utilization management, including, but not limited to, precertification of elective admissions and procedures, concurrent review of services and referral processes or protocols; (c) pre-admission testing guidelines; (d) claims payment review; (e) member grievances; (f) provider credentialing; (g) electronic submission of claims and other data required by Company; and (h) any applicable participation criteria required by the State in connection with the Government Programs. Policies also include those policies and procedures set forth in the Company's and/or Government Sponsor's manuals (as modified from time to time) as Company determines appropriate in its sole discretion; clinical policy bulletins made available via Company's internet web site; and other policies and procedures, whether made available via a password-protected web site for Participating Contractors (when available), by letter, newsletter, electronic mail or other media.

1.17 Proprietary Information. Any and all information, whether prepared by a Party, its advisors or otherwise, relating to such Party or the development, execution or performance of this Agreement whether furnished prior to or after the Effective Date. Notwithstanding the foregoing, the following shall not constitute Proprietary Information:

(a) information which was known to a receiving Party (a "Recipient") prior to receipt from the other Party (a "Disclosing Party") (as evidenced by the written records of a Recipient);
(b) information which was previously available to the public prior to a Recipient's receipt thereof from a Disclosing Party;
(c) information which subsequently became available to the public through no fault or omission

on the part of a Recipient, including without limitation, the Recipient's officers, directors, trustees, employees, agents, contractors and other representatives;

(d) information which is furnished to a Recipient by a third party which a Recipient confirms, after due inquiry, has no confidentiality obligation, directly or indirectly, to a Disclosing Party; or

(e) information which is approved in writing in advance for disclosure or other use by a Disclosing Party.

1.18 Related Parties. A party's parent, subsidiary, other Affiliate, or any of their respective officers, directors, trustees, employees, agents, contractors, subcontractors or other representatives.

1.19 State Contract. Company's contract(s) with Government Sponsors to administer Plans or Government Programs identified in the **Program Participation Schedule**.

2.0 CONTRACTOR SERVICES AND OBLIGATIONS

2.1 Provision of Services.
Contractor will make available and provide to Members those Covered Services in the service areas covered by the State Contract and this Agreement, as set forth in the **Services and Compensation Schedule**.

2.2 Non-Discrimination

2.2.1 Equitable Treatment of Members. Contractor agrees to provide, and cause Contractor Service Providers to provide, Covered Services to Members with the same degree of care and skill as customarily provided to Contractor's clients who are not Members ("non-Members"), according to generally accepted standards of practice. Contractor and Company agree that Members and non-Members should be treated equitably; to that end, Contractor agrees not to discriminate against Members on the basis of race, gender, creed, ancestry, lawful occupation, age, religion, marital status, sexual orientation, mental or physical disability, color, national origin, place of residence, health status, source of payment for services, cost or extent of Covered Services required, or any other grounds prohibited by law or this Agreement.

2.2.2 Affirmative Action. Company is a Federal contractor and an Equal Opportunity Employer which maintains an Affirmative Action Program. To the extent applicable to Contractor, Contractor agrees to comply with the following, as amended from time to time: Executive Order 11246, the Vietnam Era Veterans Readjustment Act of 1974, the Drug Free Workplace Act of 1988, Section 503 of the Rehabilitation Act of 1973, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") administrative simplification rules at 45 CFR parts 160, 162, and 164, Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b) of the Social Security Act), and any similar laws, regulations or other legal mandates applicable to transactions under or otherwise subject to any government contract of Company.

2.3 Party Representations.

2.3.1 General Representations. As set forth herein, Contractor represents, warrants and covenants (and shall require each Contractor Service Provider to represent, warrant and covenant) and/or Company represents, warrants and covenants, as applicable, that the following: (a) Contractor and Company have and shall maintain throughout the term of this Agreement all applicable license(s) and certification(s) mandated by governmental regulatory agencies; (b) Contractor and Company are, and will remain throughout the term of this Agreement, in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided hereunder, including, without limitation, statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, false claims and prohibition of kickbacks; (c) if, during the course of providing services to Members enrolled in a Plan and/or any other Government Program, a Government Sponsor or CMS requires Contractor (and/or each of its Contractor Service Providers) to become certified to participate in such programs for which Contractor and/or each Contractor Service Provider is not yet certified (the "Government Certification"), then Contractor shall either exercise best efforts to obtain such Government Certification (and to require each of its Contractor Service Providers to do so) within that period of time as required by the Government Sponsor or CMS, or, in the event that Contractor determines that it will not pursue such requisite Government Certification (and/or Contractor is not able to obtain the requisite Government Certification within that period of time as required by the Government Sponsor or CMS), then Contractor shall cease from providing services to Members enrolled in Company's Plan or other Company Government Program upon such date as mutually agreed to by the parties (provided, however, that such date is not violative of any Government Sponsor or CMS directive or applicable laws) and Contractor shall cooperate with Company in the transitioning of such Member care, where applicable, in accordance with the terms of this Agreement and in accordance with all applicable laws (including, but not limited to, those laws concerning written notice to Members of Contractor's non-par status upon a certain effective date); (d) Contractor has established an ongoing quality assurance/assessment program that includes, but is not limited to, appropriate credentialing of employees and subcontractors and shall supply to Company, if requested by Company, the relevant documentation, including, but not limited to, internal quality assurance/assessment protocols, state licenses and certifications, Federal agency certifications and/or registrations upon request; (e) all Contractor personnel employed by, associated or contracted with Contractor, including, in part, Contractor Service Providers who provide or arrange for the provision of Covered Services to Members: (i) are and will remain throughout the term of this Agreement appropriately licensed and/or certified (when and as required by state law) and, as applicable, properly supervised (when and as required by law), (ii) are qualified by education, training and experience to perform their professional duties, (iii) will act within the scope of their licensure or certification, as the case may be, and (iv) will fully comply, at all times, with Contractor's Contractor Service Provider guidelines, policies and procedures; (f) where applicable, its credentialing, privileging, and re-appointment procedures are in accordance with its policies and procedures and fulfill all applicable state and Federal standards; (g) Contractor shall require the Contractor Service Providers to comply with the applicable terms of this Agreement; (h) this Agreement has been executed by duly authorized representative of Contractor and Company; (i) executing this Agreement and performing its obligations hereunder shall not cause Contractor or Company to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed; and (j) Contractor shall ensure that appropriate oversight as it concerns each of its Contractor Service Providers.

Notwithstanding the foregoing representations, the Parties understand and agree that Company shall have the right, on an on-going basis, to review and approve Contractor's Contractor Service Provider selection criteria, which approval by Company shall not be

unreasonably withheld. Company shall have the right to disapprove of any Contractor Service Provider, provided that such right shall be exercised reasonably.

2.3.2 Government Program Representations. Company has or may seek a contract to serve beneficiaries ("Government Programs"). To the extent Company participates in such Government Programs, Contractor agrees, on behalf of itself and any subcontractors of Contractor, to be bound by all rules and regulations of, and all requirements applicable to, such Government Programs. Contractor acknowledges and agrees that all provisions of this Agreement shall apply equally to any employees, independent contractors and subcontractors of Contractor who provide or may provide services to Members of Government Programs, and Contractor represents and warrants that Contractor shall comply, and shall take all steps necessary to cause such employees, independent contractors and subcontractors to comply, with the Agreement and all Applicable Laws, and perform all requirements applicable to Government Programs. With respect to Members of Government Programs, Contractor acknowledges that compensation under this Agreement for such Members constitutes receipt of Federal funds. Contractor agrees that all services and other activities performed by Contractor under this Agreement will be consistent and comply with Company's obligations under its contract(s) with the Government Sponsor, and any applicable state regulatory agency, to offer Government Program Plans. Contractor further agrees to allow CMS, the Government Sponsor, any applicable state regulatory agency, and Company to monitor Contractor's performance under this Agreement on an ongoing basis in accordance with applicable laws, rules and regulations. Contractor acknowledges and agrees that Company may only delegate its activities and responsibilities under its contract(s) with the Government Sponsor and any applicable regulatory agency, to offer Government Program Plans in a manner consistent with applicable laws, rules and regulations, and that if any such activity or responsibility is delegated by Company to Contractor, the activity or responsibility may be revoked if CMS, the Government Sponsor or Company determine that Contractor has not performed satisfactorily.

2.3.3 Contractor represents and warrants, and shall require each of the Contractor Service Provider to warrant, that neither it nor any of its Related Parties who is and/or will be fully or partially responsible for Contractor's performance of its obligations under this Agreement has (i) pled guilty or no contest to or been convicted of any felony involving dishonesty or breach of trust; or (ii) been excluded from participation in any federal- or state-funded health program; or (iii), where applicable, been listed in the National Practitioner Data Bank or the Healthcare Integrity and Protection Data Bank (each a "Data Bank"). In the event Contractor or any of Contractor's Related Parties has an adverse action report listed in a Data Bank after the Effective Date, and, in the case a Related Party is listed, Contractor fails to terminate such Related Party's role in providing of services under this Agreement immediately upon learning of such fact, Company shall have the right, in its sole discretion and judgment, to terminate the Agreement as provided in Section 6.4 herein or to disqualify the listed person(s) from providing any part of the Services.

2.4 Contractor's Insurance.

During the term of this Agreement, Contractor shall procure and maintain, with respect to the activities in which Contractor and its employees engage pursuant to this Agreement, such policies of comprehensive general liability and other insurance at minimum levels required from time to time by Company, but in no event less than$1 million per claim, $3 million annual aggregate. Such insurance coverage shall cover the acts and omissions of Contractor, and each of Contractor's employees. Contractor agrees to deliver memorandum copies of such policies to Company upon request. Contractor agrees to make best efforts to provide to Company at least thirty (30) days

advance notice, and in any event will provide notice as soon as reasonably practicable, of any cancellation or material modification of said policies.

In addition to the above, Contractor shall require and ensure that each Contractor Service Provider shall maintain throughout the term of this Agreement comprehensive general liability insurance and automobile liability insurance in those amounts that are reasonable (but in no event less than the amounts required by applicable law) in light of those services, including Covered Services, provided by Contractor Service Provider, to Company Members.

2.5 Contractor Service Provider Information

Contractor shall provide to Company a complete list of Contractor Service Provider, including any unique names, office addresses, telephone and facsimile numbers. Contractor shall notify Company in writing within ten (10) business days of any changes to this information including, but not limited to, any additional Contractor Service Provider that joined Contractor's provider network.

2.6 Contractor Service Provider Agreements

Notwithstanding any contrary interpretation of this Agreement or any contracts between Contractor and Contractor Service Provider, Contractor acknowledges and agrees that all provisions of this Agreement applicable to Contractor shall apply with equal force to Contractor Service Provider, unless clearly applicable only to Contractor. Contractor agrees that it is Contractor's responsibility to require Contractor Service Provider to fully comply with their obligations under this Agreement , and that Contractor will take all steps necessary to enforce such requirements and to cause Contractor Service Provider to comply with and perform the terms and conditions of this Agreement.

2.7 Product Participation.

Contractor agrees to participate in the Plans and other health benefit products listed on the **Program Participation Schedule** attached hereto and made a part hereof. The parties may mutually agree in writing to increase or decrease the types of Covered Services made available to Members under this Agreement, subject to the approval of the Government Sponsor.

Nothing herein shall require that Company identify, designate or include Contractor as a preferred participant in any specific Plan or product.

2.8 Consents to Release Medical Information.

Where applicable, Contractor covenants that it will obtain from Members to whom Covered Services are provided, any necessary consents or authorizations to the release of Information and Records to Company, its agents and representatives in accordance with any applicable Federal or state law or regulation or this Agreement.

2.9 Off-Shoring of Services.

In no event shall Contractor, without Company's prior written approval, perform any services under the Agreement through any individual or entity (including, but not limited to, any employee, Contractor, subcontractor, agent, representative or other individual or entity), if such individual or entity is physically located outside of one of the fifty United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands) ("Offshore Entity"). Contractor further agrees that Contractor may not utilize the services of any Offshore Entity not audited by Company prior to the provision of services.

In the event that Company provides Contractor with prior written approval to use an Offshore Entity to perform any services for Plans, Contractor shall take all steps necessary to ensure that: (a) Offshore Entity complies with the requirements of this Agreement and any related amendment, and

(b) Contractor and Offshore Entity comply with all laws, rules and regulations, including, without limitation, CMS instructions, applicable to the performance of any services for Plans outside of one of the fifty United States or one of the United States Territories.

In no event shall Contractor, without Company's prior written approval, provide Protected Health Information (as that term is defined below) received from, or created or received by Contractor on behalf of Company, to any employee or agent, including a subcontractor, if such employee, agent or subcontractor receives, processes or otherwise has access to the Protected Health Information outside of the United States of America. 'Protected Health Information' shall have the same meaning as the term 'Protected Health Information,' as defined by 45 C.F.R. 160.103, limited to the information created or received by Delegated Entity from or on behalf of Company.

3.0 COMPANY OBLIGATIONS

3.1 Company's Covenants.
Company shall provide Members with a means to identify themselves to Contractor (e.g., identification cards), and a general description of products. Company shall provide Contractor with a means to check eligibility, including providing Contractor with eligibility files in a HIPAA-compliant electronic format at least prior to the 2nd day of each month under this Agreement. Company will use best efforts to assure the accuracy and currency of that information.

3.2 Company Representations.
Company represents and warrants that: (a) it, where applicable, is licensed to offer, issue and administer Plans in the service areas covered by this Agreement by the applicable regulatory authority ("License"); (b) it will not lose such License involuntarily during the course of this Agreement; (c) it is, and will remain throughout the term of this Agreement, substantially in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided hereunder; including without limitation, any applicable prompt payment statutes and regulations or capital reserve requirements; provided however, that for the purposes of (b) and (c), Contractor will have no basis for termination to the extent that such action does not impact the obligations of Company under this Agreement; (d) this Agreement has been executed by its duly authorized representative; and (e) executing this Agreement and performing its obligations hereunder shall not cause Company to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

4.0 COMPENSATION; MEMBER BILLING

4.1 Compensation.
Company shall provide Compensation to Contractor for Covered Services provided to Members in accordance with the terms of the **Services and Compensation Schedule**, which is attached hereto and made a part of this Agreement hereof.

To the extent that Company delegates, to Contractor, any services under this Agreement (whereby the terms of such delegated services arrangements are set forth in unique delegation addenda attached to this Agreement), Contractor understands and agrees that no additional compensation shall be payable to Contractor for such delegated services in addition to the compensation set forth in the **Services and Compensation Schedule** to this Agreement.

4.2 Member Billing.
Contractor may bill or charge Members only in the following circumstances: (a) applicable Copayments, Coinsurance and/or Deductibles, if any, not collected at the time that Covered Services are rendered; and (b) for services that are not Covered Services only if: (i) the Member's

Plan provides and/or Company confirms that the specific services are not covered; (ii) the Member was advised in writing prior to the services being rendered that the specific services may not be Covered Services; and (iii) the Member agreed in writing to pay for such services after being so advised. Contractor acknowledges that Company's denial or adjustment of payment to Contractor based on Company's performance of utilization management or otherwise is not a denial of Covered Services under this Agreement or under the terms of a Plan, except if Company confirms otherwise. Contractor may bill or charge individuals who were not Members at the time that services were rendered.

Contractor hereby agrees that in no event, including, but not limited to the failure, denial or reduction of payment by Company, insolvency of Company or breach of this Agreement, shall Contractor bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse (i) against Members or persons acting on their behalf (other than Company) or (ii) any settlement fund or other *res* controlled by or on behalf of, or for the benefit of, a Member for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance, Deductibles made in accordance with the terms of the applicable Plan. Contractor further agrees that this Section 4.2: (a) shall survive the expiration or termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) supersedes any oral or written contrary agreement or waiver now existing or hereafter entered into between Contractor and Members or persons acting on their behalf.

To protect Members, Contractor agrees not to seek or accept or rely upon waivers of the Member protections provided by this Section 4.2.

5.0 COMPLIANCE WITH POLICIES

5.1 Policies.

Contractor agrees to comply with Policies. Neither party may modify the Policies without the prior written consent of the other party (which consent shall not be unreasonably withheld or delayed); provided, however, either party may modify the Policies to comply with applicable Mandates upon at least thirty (30) days' prior written notice to the other party. Notwithstanding the foregoing, either party may object to such proposed modification during the thirty-day notice period in the event that such objecting party reasonable believes, and provides a full explanation in support of the fact, that such proposed modification will have a material adverse financial impact upon such party; provided, further, at that time, the parties will negotiate in good faith an appropriate modification to the Policies (taking into consideration each party's interpretation of the subject Mandate(s) and the subject parties' concerns with regard to the proposed modification); provided, further, in the event the parties are unable to agree to any such modification to the Policies within that thirty-day notice period, then either party may terminate this Agreement upon written notice to the other party, which effective date of termination shall be at least one hundred eighty (180) days following the receipt of such written notice of termination. During the aforementioned one hundred eighty (180) day period, the subject Policy shall remain in its original form and not be modified unless any such regulatory agency and/or accreditation body expressly directs (either in direct response to an inquiry from either party to this Agreement or by any other means) the effectuation of such modification during the remaining one hundred eighty (180) days of the Agreement.

5.2 Notices and Reporting.

To the extent neither prohibited by law nor violative of applicable privilege, Contractor agrees to provide notice to Company, and shall provide all information reasonably requested by Company regarding the nature, circumstances, and disposition, of: (a) any litigation brought against Contractor or any of its employees, that is related to the provision of Contractor Services and could have a material impact on the Covered Services provided to Members; (b) any investigation

initiated by any government agency or program against or involving Contractor or any of its employees that does or could materially impact and/or adversely affect Contractor's licensure, or certification to participate in the Medicare, Medicaid or other Government Programs; (c) any change in the ownership or management of Contractor other than a change in which beneficial ownership and control remains with the existing owners, directors, or officers; and (d) any material change in services provided by Contractor and Contractor Service Providers or licensure status related to such services that has a material impact on the delivery of services under this Agreement. Contractor agrees to use best efforts to provide Company with prior notice of, and in any event will provide notice as soon as reasonably practicable notice of, any actions taken by Contractor described in this Section 5.2.

5.3 Information and Records.

5.3.1 Maintenance of Information and Records. Contractor agrees (a) to maintain Information and Records (as such terms are defined in Section 5.3.2) in a current, detailed, organized and comprehensive manner and in accordance with customary practice, applicable Federal and state laws, and accreditation standards; (b) that all Member medical records and Confidential Information shall be treated as confidential and in accordance with applicable laws; (c) to maintain such Information and Records for the longer of six (6) years after the last date Contractor Services were provided to Members, or the period required by applicable laws, rules or regulations. This Section 5.3.1 shall survive the termination of this Agreement, regardless of the cause of the termination.

5.3.2 Access to Information and Records. Contractor agrees that (a) Company (including Company's authorized designee) shall have access to all data and information obtained, created or collected by Contractor related to Members relevant to this Agreement and necessary for payment of claims, including, without limitation, Confidential Information ("Information"); (b) Company (including Company's authorized designee) and Federal, state, and local governmental authorities and their agents having jurisdiction, upon request, shall have access, for any reasonable purpose under the terms of this Agreement, to all books, records and other papers (including, but not limited to, contracts and medical and financial records) and information relating to this Agreement and to those services rendered by Contractor to Members ("Records"); (c) consistent with the consents and authorizations required by Section 2.8 hereof, Company or its agents or designees shall have access to Member Records for the purpose of assessing quality of services, conducting audits, and, where applicable, performing utilization management functions; (d) applicable Federal and state authorities and their agents shall have access to Records for assessing the quality of services or investigating Member grievances or complaints; and (e) where applicable, Members shall have access to their health information as required by 45 C.F.R. § 164.524 and applicable state law, be provided with an accounting of disclosures of information when and as required by 45 C.F.R. § 164.528 and applicable state law, and have the opportunity to amend or correct the information as required by 45 C.F.R. § 164.526 and applicable state law. Contractor agrees to supply copies of Information and Records within fourteen (14) days of the receipt of a request, where practicable, and in no event later than the date required by any applicable law or regulatory authority. This Section 5.3.2 shall survive the termination of this Agreement, regardless of the cause of termination.

5.4 Accreditation and Review Activities.
Contractor agrees to cooperate with any review of Company or a Plan conducted by the National Committee for Quality Assurance (NCQA) or a state or Federal agency with authority over Company and/or the Plan, as applicable.

5.5 Proprietary Information; Rights and Responsibilities. Each Party agrees that the Proprietary Information of the other Party is the exclusive property of such Party and that each Party has no right, title or interest in the same. Each Party agrees to keep the Proprietary Information and this Agreement strictly confidential and agrees not to disclose any Proprietary Information or the contents of this Agreement to any third party, except to governmental authorities having jurisdiction and, in the case of Company's disclosure, to Members, consultants and vendors under contract with Company, or as otherwise directed by the other Party. Except as otherwise required under applicable Federal or state law, each Party agrees to not use any Proprietary Information of the other Party, and at the request of the other Party hereto, return any Proprietary Information upon termination of this Agreement for whatever reason. This Section 5.5.1 shall survive the termination of this Agreement for one (1) year, regardless of the cause of termination.

6.0 TERM AND TERMINATION

6.1 Term.
This Agreement shall be effective for an initial term of _____ [Identify Initial Term Period] (___) years from the Effective Date (the "Initial Term"), and thereafter shall automatically renew for subsequent additional terms of one (1) year each, unless and until terminated in accordance with this Article 6.0.

6.2 Termination without Cause.
This Agreement may be terminated without cause at any time by either Party upon at least one hundred eighty (180) days prior written notice to the other Party; provided, however, Contractor may not terminate this Agreement without cause during the Initial Term of this Agreement.

6.3 Termination for Breach.
This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party upon material default or substantial breach by such Party of one or more of its obligations hereunder, unless such material default or substantial breach is cured within sixty (60) days of the notice of termination; provided, however, if such material default or substantial breach is incapable of being cured within such sixty (60) day period, any termination pursuant to this Section 6.3 will be ineffective for the period reasonably necessary to cure such breach if the breaching party has taken all steps reasonably capable of being performed within such sixty (60) day period. Notwithstanding the foregoing, (a) in the event the material breach is nonpayment by Company of material amounts due Contractor hereunder, Contractor may terminate this Agreement upon thirty (30) days prior written notice of such termination, unless such breach is cured within thirty (30) days of the notice of termination and (b) the effective date of such termination may be extended pursuant to Section 6.6 herein.

6.4 Immediate Termination or Suspension.
Any of the following events shall result in the immediate termination or suspension of this Agreement by Company, upon notice to Contractor, at Company's discretion at any time: (a) the withdrawal, expiration or non-renewal of any Federal, state or local license, certificate, approval or authorization of Contractor the loss of which has a material impact on Contractor's performance of this Agreement; (b) the bankruptcy or receivership of Contractor, or an assignment by Contractor for the benefit of creditors; (c) the loss or material limitation of Contractor's insurance; (d) a reasonable determination by Company that Contractor's continued provision of Services could result in harm to Members and that such potential harm cannot be avoided by other means, such as the termination of a Contractor Service Provider; (e) the debarment or suspension of Contractor or any of Contractor's Related Parties from participation in any governmental sponsored program, including, but not limited to, Government Programs, Medicaid and Medicare and, in the case a Related Party is debarred or suspended, Contractor fails to terminate such Related Party's role in

providing of services under this Agreement immediately upon learning of such fact; (f) the conviction of Contractor for any felony; (g) the revocation or suspension of Contractor's accreditation by any applicable accrediting agency recognized by Company; (h) change of control of Contractor to an entity not acceptable to Company, other than a change in which beneficial ownership and control remains in the then existing owners, directors, or officers.; or (i) any fraud by Contractor or Contractor's Related Parties and, in the case such fraud is perpetrated by a Related Party, Contractor fails to terminate such Related Party's role in providing of services under this Agreement immediately upon learning of such fraud. To protect the interests of Members, Contractor will provide immediate notice to Company of any of the aforesaid events, including notification of impending bankruptcy. Upon Company's request, Company shall provide all known details of the nature, circumstances, and disposition of any suits, claims, actions, investigations or listings to Company.

Any of the following events shall result in the immediate termination or suspension of this Agreement by Contractor, upon notice to Company, at Contractor's discretion at any time: (a) the withdrawal, expiration or non-renewal of any Federal, state or local license, certificate, approval or authorization of Company the loss of which has a material impact on Contractor's performance of this Agreement; (b) the bankruptcy or receivership of Company, or an assignment by Company for the benefit of creditors; (c) the conviction of Company for any felony; or (d) change of control of Company to an entity not acceptable to Contractor. Company will provide immediate notice to Contractor of any of the aforesaid events, including notification of impending bankruptcy. Upon Contractor's request, Contractor shall provider all known details of the nature, circumstances, and disposition of any suits, claims, actions, investigations or listings to Company.

6.5 Obligations Following Termination.
Upon notice of expiration or termination of this Agreement or of a Plan, Contractor shall cooperate with Company and comply with Policies, if any, in the transfer of Members to other service vendors providing Contractor Services.

6.6 Obligations During Dispute Resolution Proceedings.
In the event of any dispute between the Parties in which a Party has provided notice of termination under Section 6.3 and the dispute is required to be resolved or is submitted for resolution under Article 8.0 below, the termination of this Agreement shall be stayed and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

7.0 RELATIONSHIP OF THE PARTIES

7.1 Independent Contractor Status; Indemnification.
The relationship between Company and Contractor, as well as their respective employees and agents, is that of independent contractors, and neither shall be considered an agent or representative of the other party for any purpose, nor shall either hold itself out to be an agent or representative of the other for any purpose. The parties hereby agree to indemnify and hold each other harmless, including any Affiliates, officers, employees and agents, against any loss, liability, damage, costs and expenses (including any attorneys' fees) suffered or incurred by the other in connection with any (including any threatened or proposed) action, suit, proceeding, regulatory proceeding, demand, assessment, judgment arising out of or related to the indemnifying party's and/or the indemnifying party's agent's acts and/or omissions under the terms of this Agreement. This provision shall survive the expiration or termination of this Agreement, regardless of the reason for termination.

7.2 Use of Name.
Contractor consents to the use of Contractor's name and other, non-trademark, identifying and

descriptive material in provider directories and in other materials and marketing literature of Company in all formats, including, but not limited to, electronic media. Contractor may use Company's names, logos, trademarks or service marks in marketing materials or otherwise, upon receipt of Company's prior written consent, which shall not be unreasonably withheld.

7.3 Interference with Contractual Relations.
Contractor shall not engage in activities with the intent of causing Company to lose existing or potential Members, and shall not: (a) advise Company customers, Plan Sponsors or other entities currently under contract with Company to cancel, or not renew said contracts; (b) directly impede or interfere with negotiations which Company is conducting for the provision of health benefits or Plans; or (c) use or disclose to any third party membership lists acquired during the term of this Agreement for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this Section 7.3 is intended or shall be deemed to restrict (i) any communication between Contractor and a Member determined by Contractor to be necessary or appropriate for the provision of Services. This Section shall continue to be in effect for a period of one (1) year after the expiration or termination of this Agreement. Company shall not (a) advise Contractor customers, Plan Sponsors or other entities currently under contract with Contractor or its affiliates to cancel, or not renew said contracts; (b) use or disclose to any third party membership or provider lists acquired during the term of, and solely pursuant to, this Agreement for the purpose of soliciting individuals who were or are Members or Contractors or otherwise to compete with Company.

8.0 DISPUTE RESOLUTION

8.1 Member Grievance Dispute Resolution.
Contractor agrees to (a) cooperate with and participate in Company's applicable appeal, grievance and external review procedures (including, but not limited to, Government Program appeals and expedited appeals procedures), (b) provide Company with the information necessary to resolve same, and (c) abide by decisions of the applicable appeals, grievance and review committees.

8.2 Dispute Resolution.
The parties shall attempt in good faith to resolve any dispute arising out of or relating to this Agreement promptly by negotiation between executives who have authority to settle the controversy. If such dispute is not resolved in the normal course of business, then either party may provide written notice of the outstanding dispute to the other party (consistent with the terms of this Section 8.2 as set forth herein). Within (15) days after delivery of the notice, the receiving party shall submit to the other a written response. The notice and the response shall include (a) a statement of each party's position and a summary of arguments supporting that position, and (b) the name and title of the executive who will represent that party and of any other person who will accompany the executive. Within (30) days after delivery of the disputing party's notice, the executives of both parties shall meet at a mutually convenient time and place, and thereafter as often as they reasonably deem necessary, to attempt to resolve the dispute. All reasonable requests for information made by one party to the other will be honored. All negotiations pursuant to this provision are confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rues of evidence. If the dispute is not resolved by negotiation between executives, then either party may institute arbitration in accordance with Section 8.3 of this Agreement. Discussions and negotiations held pursuant to this Section 8.2 shall be treated as inadmissible compromise and settlement negotiations for purposes of applicable rules of evidence.

8.3 Arbitration.

8.3.1 Submission of Claim or Controversy to Arbitration. Any controversy or claim arising out of

or relating to this Agreement or the breach, termination, or validity thereof, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration administered by the American Arbitration Association ("AAA") and conducted by a sole Arbitrator ("Arbitrator") in accordance with the AAA's Commercial Arbitration Rules ("Rules"). The arbitration shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16, to the exclusion of state laws inconsistent therewith or that would produce a different result, and judgment on the award rendered by the Arbitrator (the "Award") may be entered by any court having jurisdiction thereof. A stenographic record shall be made of all testimony in any arbitration in which any disclosed claim or counterclaim exceeds $250,000. An Award for $250,000 or more shall be accompanied by a short statement of the reasoning on which the Award rests.

8.3.2 Appeal of Arbitration Award. In the event a Party believes there is a clear error of law and within thirty (30) days of receipt of an Award of $250,000 or more (which shall not be binding if an appeal is taken), a Party may notify the AAA of its intention to appeal the Award to a second Arbitrator (the "Appeal Arbitrator"), designated in the same manner as the Arbitrator except that the Appeal Arbitrator must have at least twenty (20) years' experience in the active practice of law or as a judge. The Award, as confirmed, modified or replaced by the Appeal Arbitrator, shall be final and binding, and judgment thereon may be entered by any court having jurisdiction thereof. No other arbitration appeals may be made.

8.3.3 Confidentiality. Except as may be required by law or to the extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an Award, neither a Party nor an arbitrator may disclose the existence, content, record, status or results of a negotiation or arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to a negotiation or arbitration, or reflecting the existence, content, record, status, or results of a negotiation ("Negotiation Record") or arbitration ("Arbitration Record"), is confidential. The arbitration hearing shall be closed to any person or entity other than the arbitrator, the parties, witnesses during their testimony, and attorneys of record. Upon the request of a Party, an arbitrator may take such actions as are necessary to enforce this Section 8.3.3, including the imposition of sanctions.

8.3.4 Pre-hearing Procedure for Arbitration. The Parties will cooperate in good faith in the voluntary, prompt and informal exchange of all documents and information (that are neither privileged nor proprietary) relevant to the dispute or claim, all documents in their possession or control on which they rely in support of their positions or which they intend to introduce as exhibits at the hearing, the identities of all individuals with knowledge about the dispute or claim and a brief description of such knowledge, and the identities, qualifications and anticipated testimony of all experts who may be called upon to testify or whose report may be introduced at the hearing. The Parties and Arbitrator will make commercially reasonable efforts to conclude the document and information exchange process within sixty (60) calendar days after all pleadings or notices of claims have been received. At the request of a Party in any arbitration in which any disclosed claim or counterclaim exceeds $250,000, the Arbitrator may also order pre-hearing discovery by deposition upon good cause shown. Such depositions shall be limited to a maximum of three (3) per Party and shall be limited to a maximum of six (6) hours' duration each. As they become aware of new documents or information (including experts who may be called upon to testify), all Parties remain under a continuing obligation to provide relevant, non-privileged documents, to supplement their identification of witnesses and experts, and to honor any understandings between the Parties regarding documents or information to be exchanged. Documents that have not been previously exchanged, or witnesses and experts not previously identified, will not be considered by the Arbitrator at the hearing. Fourteen (14) calendar days before the hearing,

the Parties will exchange and provide to the Arbitrator (a) a list of witnesses they intend to call (including any experts) with a short description of the anticipated direct testimony of each witness and an estimate of the length thereof, and (b) premarked copies of all exhibits they intend to use at the hearing.

8.3.5 Arbitration Award. The arbitrator may award only monetary relief and is not empowered to award damages other than set forth in this Agreement. The Award shall be in satisfaction of all claims by all Parties. Arbitrator fees and expenses shall be borne equally by the Parties. Postponement and cancellation fees and expenses shall be borne by the Party causing the postponement or cancellation. Fees and expenses incurred by a Party in successfully enforcing an Award shall be borne by the other Party. Except as otherwise provided in this Agreement, each Party shall bear all other fees and expenses it incurs, including all filing, witness, expert witness, transcript, and attorneys' fees.

8.3.6 Survival. The provisions of Section 8.3 shall survive expiration or termination of this Agreement, regardless of the cause giving rise hereto.

8.4 Arbitration Solely Between Parties; No Consolidation or Class Action.
Company and Contractor agree that any arbitration or other proceeding related to a dispute arising under this Agreement shall be conducted solely between them. Neither Party shall request, nor consent to any request, that their dispute be joined or consolidated for any purpose, including without limitation any class action or similar procedural device, with any other proceeding between such Party and any third party.

9.0 CONFIDENTIALITY OF MEMBER INFORMATION, HIPAA AND GLBA COMPLIANCE

9.1 Confidentiality, HIPAA and GLBA. Contractor and Company agree that confidentiality of Member medical information must be safeguarded. Contractor agrees to ensure that any information related to a Member is to be kept strictly confidential in accordance with all state and federal laws regarding, among other things, the confidentiality of patient records and shall not be released to any third party except as set forth in Article 5 and this Article 9 of the Agreement. According to the terms of Company's HMO enrollment forms, agreements with Members and applicable law, Company shall be able to obtain Member information from Contractor without additional written release by the Member. Each party agrees to comply with all applicable requirements of TITLE II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 and its related regulations ("HIPAA"), including any and all requirements regarding the privacy and security of protected health information. It is understood and agreed that Contractor is, and will be, a "business associate" of Company for purposes of HIPAA and a "service provider" of Company for purposes of GLBA because of the delegated functions it is performing on behalf of Company.

9.2 HIPAA and GLBA Definitions. For purposes of Sections 9.2 through 9.8 the following terms shall have the meaning set forth below:

a. C.F.R. "C.F.R." means the Code of Federal Regulations.

b. Designated Record Set. "Designated Record Set" has the meaning assigned to such term in 45 C.F.R. 164.501.

c. Member Information. "Member Information" means nonpublic personal financial and health

information about a customer, whether in paper, electronic or other form. Member Information includes any such information provided by the customer as part of a request for information about, or an application for, a Company insurance product or service, even if no such insurance product or service is subsequently provided to the customer.

d. Electronic Protected Health Information. "Electronic Protected Health Information" means information that comes within paragraphs 1(i) or 1(ii) of the definition of "Protected Health Information", as defined in 45 C.F.R. 160.103.

e. Individual. "Individual" shall have the same meaning as the term "individual" in 45 C.F.R. 164.501 and shall include a person who qualifies as personal representative in accordance with 45 C.F.R. 164.502 (g).

f. Privacy and Security Rules. "Privacy and Security Rules" means the regulations promulgated by the Department of Health and Human Services at 45 C.F.R. Parts 160-164, Subparts A, C and E, which regulations implement the privacy and security requirements of the Administrative Simplification provisions of HIPAA.

g. Protected Health Information "Protected Health Information" shall have the same meaning as the term "Protected Health Information", as defined by 45 C.F.R. 160.103, limited to the information created or received by Contractor from or on behalf of Company.

h. Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 C.F.R. 164.501.

i. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

j. Security Incident. "Security Incident" shall have the same meaning as the term "security incident" in 45 C.F.R. 164.304.

k. Service Contractor. "Service Contractor" means any person or entity that provides services to Company and maintains, processes or otherwise is permitted access to Company's Member Information.

l. Standard Transactions. "Standard Transactions" means the electronic health care transactions for which HIPAA standards have been established, as set forth in 45 C.F.R. Parts 160-162.

9.3 Obligations and Activities of Contractor with Respect to HIPAA.

a. Contractor agrees to not use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required by Law. Contractor shall also comply with any further limitations on uses and disclosures agreed by Company in accordance with 45 C.F.R. 164.522 provided that such agreed upon limitations have been communicated to Contractor according with Section 12.5.1.c of this Agreement.

b. Contractor agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

c. Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of Protected Health Information by Contractor in violation of the requirements of this Agreement.

d. Contractor agrees to report to Company any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.

e. Contractor agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Contractor on behalf of Company agrees to the same restrictions and conditions that apply through this Agreement to Contractor with respect to such information. In no event shall Contractor, without Company's prior written approval, provide Protected Health Information received from, or created or received by Contractor on behalf of Company, to any employee or agent, including a subcontractor, if such employee, agent or subcontractor receives, processes or otherwise has access to the Protected Health Information outside of the United States.

f. Contractor agrees to provide access, at the request of Company, and in the time and manner designated by Company, to Protected Health Information in a Designated Record Set, to Company or, as directed by Company, to an Individual in order to meet the requirements under 45 C.F.R. 164.524. Company's determination of what constitutes "Protected Health Information" or a "Designated Record Set" shall be final and conclusive. If Contractor provides copies or summaries of Protected Health Information to an Individual it may impose a reasonable, cost-based fee in accordance with 45 C.F.R. 164.524(c)(4).

g. Contractor agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Company directs or agrees to pursuant to 45 C.F.R. 164.526 at the request of Company or an Individual, and in the time and manner designated by Company. Contractor shall not charge any fee for fulfilling requests for amendments. Company's determination of what Protected Health Information is subject to amendment pursuant to 45 C.F.R. 164.526 shall be final and conclusive.

h. Contractor agrees to make (i) internal practices, books, and records, including policies and procedures relating to the use and disclosure of Protected Health Information received from, or created or received by Contractor on behalf of, Company, and (ii) policies, procedures, and documentation relating to the safeguarding of Electronic Protected Health Information available to the Company, or at the request of the Company to the Secretary, in a time and manner designated by the Company or the Secretary, for purposes of the Secretary determining Company's compliance with the Privacy and Security Rules.

i. Contractor agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Company to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. 164.528.

j. Contractor agrees to provide to Company, in the time and manner designated by Company, the information collected in accordance with Section 9.3i of this Agreement, to permit Company to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. 164.528.

k. Contractor acknowledges that it shall request from the Company and so disclose to its affiliates, subsidiaries, agents and subcontractors or other third parties, only the minimum Protected Health Information necessary to perform or fulfill a specific function required or permitted hereunder.

l. With respect to Electronic Protected Health Information, Contractor shall implement

administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of Company, as required by 45 C.F.R. Part 164, Subpart C.

m. With respect to Electronic Protected Health Information, Contractor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information, agrees to implement reasonable and appropriate safeguards to protect it.

n. Contractor shall report to Company any Security Incident of which it becomes aware.

o. If Contractor conducts any Standard Transactions on behalf of Company, Contractor shall comply with the applicable requirements of 45 C.F.R. Part 160-162.

9.4 Permitted Uses and Disclosures by Contractor

9.4.1 General Use and Disclosure. Except as otherwise limited in this Agreement, Contractor may use or disclose Protected Health Information to perform its obligations and Services to Company, provided that such use or disclosure would not violate the Privacy and Security Rules if done by Company or the minimum necessary policies and procedures of the Company.

9.4.2 Specific Use and Disclosure Provisions

a. Except as otherwise limited in this Agreement, Contractor may use Protected Health Information for the proper management and administration of the Contractor or to carry out the legal responsibilities of the Contractor.

b. Except as otherwise limited in this Agreement, Contractor may disclose Protected Health Information for the proper management and administration of the Contractor, provided that disclosures are Required By Law, or Contractor obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Contractor of any instances of which it is aware in which the confidentiality of the information has been breached.

c. Except as otherwise limited in this Agreement, Contractor may use Protected Health Information to provide Data Aggregation services to Company as permitted by 45 C.F.R. 164.504(e)(2)(i)(B).

d. Contractor may use Protected Health Information to report violation of law to appropriate Federal and state authorities, consistent with 45 C.F.R. 164.502 (j)(1).

9.5 Obligations of Company With Respect to HIPAA.

9.5.1 Provisions for Company to Inform Contractor of Privacy Practices and Restrictions

a. Company shall notify Contractor of any limitation(s) in Company's notice of privacy practices that Company produces in accordance with 45 C.F.R. 164.520, to the extent that such limitation(s) may affect Contractor's use or disclosure of Protected Health Information.

b. Company shall provide Contractor with any changes in, or revocation of, permission by

Individual to use or disclose Protected Health Information, to the extent that such changes affect Contractor's use or disclosure of Protected Health Information.

c. Company shall notify Contractor of any restriction to the use or disclosure of Protected Health Information that Company has agreed to in accordance with 45 C.F.R. 164.522, to the extent that such restriction may affect Contractor's use or disclosure of Protected Health Information.

9.5.2 Permissible Requests by Company. Except as may be set further in Section 9.4.2, Company shall not request Contractor to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy and Security Rules if done by Company.

9.6 Obligations of Contractor With Respect to GLBA.

a. Contractor agrees to implement a comprehensive written information security program that includes administrative, technical and physical safeguards for the protection of Member Information that are appropriate to Contractor's size, complexity, nature and scope of activities, and that is designed to:

(i) ensure the integrity and confidentiality of Member Information;
(ii) protect against any anticipated threats or hazards to the security or integrity of Member Information; and
(iii) protect against unauthorized access to, or use of, Member Information that could result in substantial harm or inconvenience to any customer.

b. Contractor agrees to ensure that any agent, including a subcontractor, to whom it provides Member Information received from, or created or received by Contractor on behalf of Company, agrees to the same restrictions and conditions that apply through this Agreement to Contractor with respect to such Member Information.

c. In no event shall Contractor, without Company's prior written approval, provide Member Information (received from, or created or received by Contractor on behalf of Company) to any employee or agent, including a subcontractor, if such employee, agent or subcontractor receives, processes, or otherwise has access to the Member Information outside of the United States.

d. Contractor agrees to make policies, procedures, and documentation relating to the safeguarding of Member Information available to Company, or at the request of Company to the applicable state department of insurance, in a time and manner designated by the Company or department of insurance, for purposes of the department determining Company's compliance with GLBA.

e. Contractor agrees to affirm in writing, upon request from Company from time to time, Contractor's continued compliance with its obligations under this Agreement.

9.7 Term and Termination.

a. Term. Notwithstanding any provision to the contrary contained in this Agreement, the provisions of this Article 9 shall survive termination of this Agreement and shall only terminate when all of the Protected Health Information and Member Information provided by Company to Contractor, or created or received by Contractor on behalf of Company, is destroyed or returned to Company, or, if it is infeasible to return or destroy Protected Health

Information and Member Information, protections are extended to such information, in accordance with the provisions in this Section.

b. Effect of Termination.

i. Except as provided in paragraph b(ii) of this Section 9.7, upon termination of this Agreement, for any reason, Contractor shall return or destroy all Protected Health Information and Member Information received from Company, or created, maintained, transmitted or received by Contractor on behalf of Company. This provision shall apply to Protected Health Information and Member Information that is in the possession of subcontractors or agents of Contractor. Contractor shall retain no copies of the Protected Health Information or Member Information.

ii. In the event the Contractor determines that returning or destroying the Protected Health Information or Member Information is infeasible, Contractor shall provide to Company notification of the conditions that make return or destruction infeasible and the purposes of Contractor's continued use. Upon mutual agreement of the parties that return or destruction of Protected Health Information or Member Information is infeasible and Contractor has a legitimate purpose in continued use of the Protected Health Information or Member Information, Contractor shall extend the protection of this Agreement to such Protected Health Information or Member Information and limit further uses and disclosures of such Protected Health Information or Member Information to those purposes that make the return or destruction infeasible, for so long as Contractor maintains such Protected Health Information or Member Information.

9.8 Miscellaneous.

a. Regulatory References. A reference in this Agreement to a section in the Privacy and Security Rules means the section as in effect or as amended.

b. Amendment. Upon the enactment of any law or regulation affecting the use or disclosure of Protected Health Information, the safeguarding of Electronic Protected Health Information or the safeguarding of Member Information, or the publication of any decision of a court of the United States or any state relating to any such law or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, either party may, by written notice to the other party, amend the Agreement in such manner as such party determines necessary to comply with such law or regulation. If the other party disagrees with such amendment, it shall so notify the first party in writing within thirty (30) days of the notice. If the parties are unable to agree on an amendment within thirty (30) days thereafter, then either party may terminate this Agreement upon written notice to the other party, which effective date of termination shall be at least one hundred eighty (180) days following the receipt of such written notice of termination.

c. Interpretation. Any ambiguity in this Article 9 shall be resolved to permit Company to comply with the Privacy and Security Rules and GLBA. In the event of any inconsistency or conflict between this Article 9 and any other agreement between the parties, the terms, provisions and conditions of this Article 9 shall govern and control.

d. No third party beneficiary. Nothing express or implied in this Article 9 is intended to confer, nor shall anything herein confer, upon any person other than the parties and the respective successors or assigns of the parties, any rights, remedies, obligations, or liabilities whatsoever.

10.0 MISCELLANEOUS

10.1 Amendments.

This Agreement constitutes the entire understanding of the Parties hereto and no changes, amendments or alterations shall be effective unless signed by both Parties, except as expressly provided herein. Notwithstanding the foregoing, at Company's discretion, Company may, upon at least thirty (30) days' advance written notice (unless a shorter period is required by applicable law, order or directive), amend this Agreement in order to comply with applicable law or regulation, or any order or directive of any governmental agency, including without limitation any requirements relating to the Plan or other Company Government Programs set forth in contracts or requests for proposals awarded to Company. In the event that Contractor reasonably believes such amendment is likely to have a material adverse financial impact upon Contractor, Contractor agrees to notify Company, during that thirty (30) day notice period, specifying the specific bases demonstrating a likely material adverse financial impact. Thereafter, the Parties will attempt to negotiate in good faith an appropriate additional amendment to this Agreement. In the event the parties are unable to agree to any such amendment within thirty (30) days of Contractor's notice, then either party may terminate this Agreement upon written notice to the other party, which effective date of termination shall be at least one hundred eighty (180) days following the receipt of such written notice of termination. During the aforementioned one hundred eighty (180) day period, the terms of this Agreement shall remain in their original form and not be amended unless any such regulatory agency and/or accreditation body expressly directs (either in direct response to an inquiry from either party to this Agreement or by any other means) the effectuation of such amendment during the remaining one hundred eighty (180) days of the Agreement.

10.2 Waiver.

The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, all waivers must be in writing and signed by an authorized officer of the Party to be charged. Contractor waives any claims or cause of action for fraud in the inducement or execution related hereto.

10.3 Governing Law.

This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State where Contractor is located.

10.4 Liability.

Either Party's liability, if any, for damages to the other Party for any cause whatsoever arising out of or related to this Agreement, and regardless of the form of the action, shall be limited to the damaged Party's actual damages. Neither Party shall be liable for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whatsoever sustained as a result of a breach of this Agreement or any action, inaction, alleged tortious conduct, or delay by the other Party.

10.5 Severability.

Any determination that any provision of this Agreement or any application thereof is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Neither Party shall assert or claim that this Agreement or any provision hereof is void or voidable if such Party performs under this Agreement without prompt and timely written objection.

10.6 Successors; Assignment.

This Agreement relates solely to the provision of Covered Services by Contractor and its contracted staff and Contractor Service Provider and does not apply to any other organization which succeeds to Contractor assets, by merger, acquisition or otherwise. Neither Party may assign its rights or delegate its duties and obligations under this Agreement, except as specifically provided herein, without the prior written consent of the other Party, which consent may not be unreasonably withheld; provided, however, that either party may assign its rights or delegate its duties and obligations to an Affiliate so long as any such assignment or delegation will not have a material impact upon the rights, duties and obligations of the other party.

10.7 Headings.

The headings contained in this Agreement are included for purposes of convenience only, and shall not affect in any way the meaning or interpretation of any of the terms or provisions of this Agreement.

10.8 Notices.

Unless otherwise specified herein, any notice required to be given pursuant to the terms and provisions hereof shall be effective only if given in writing and sent by overnight delivery service with proof of receipt, or by certified mail return receipt requested. Notices shall be sent to the following addresses (which may be changed by giving notice in conformity with this Section 10.8). Each Party shall notify the other Party of any changes in their respective information provided below.

To Contractor at:

[Placeholder]

and to Company at:

[Placeholder]

10.9 Remedies.

Notwithstanding Sections 8.3 and 10.4, the Parties agree that each has the right to seek any and all remedies at law or equity in the event of breach or threatened breach of Section(s) 5.5, 6.6 and 7.3.

10.10 Non-Exclusivity.

This Agreement is not exclusive, and nothing herein shall preclude either Party from contracting with any other person or entity for any purpose. Company makes no representation or guarantee as to the number of Members who may select or be assigned to Contractor.

10.11 Force Majeure.

If either Party shall be delayed or interrupted in the performance or completion of its obligations hereunder by any act, neglect or default of the other Party, or by an embargo, war, act of terror, riot, incendiary, fire, flood, earthquake, epidemic or other calamity, act of God or of the public enemy, governmental act (including, but not restricted to, any government priority, preference, requisition, allocation, interference, restraint or seizure, or the necessity of complying with any governmental order, directive, ruling or request) then the time of completion specified herein shall be extended for a period equivalent to the time lost as a result thereof. This Section 10.11 shall not apply to either Party's obligations to pay any amounts owing to the other Party, nor to any strike or labor dispute involving such Party or the other Party.

10.12 Survival.

In addition to those provisions which by their terms survive expiration or termination of this Agreement, Sections 5.5, 6.5, 7.3 and this Article 10 shall survive expiration or termination of this Agreement, regardless of the cause giving rise thereto.

10.13 Entire Agreement.

This Agreement (including any attached exhibits and schedules) constitutes the complete and sole contract between the Parties regarding the subject hereof and supersedes any and all prior or contemporaneous oral or written representations, communications, proposals or agreements not expressly included herein and may not be contradicted or varied by evidence of prior, contemporaneous or subsequent oral representations, communications, proposals, agreements, prior course of dealings or discussions of the Parties. There are no oral agreements between the Parties. Contractor represents that it has not relied on any data, financial analysis, reports, notes, proposals, conclusions or projections, whether made orally or in writing, made by Company or any of its representatives, agents, employees or advisors, in connection with negotiation, acceptance, execution or delivery of the Agreement by Contractor.

10.14 Counterparts.

This Agreement may be executed in separate counterparts, each of which shall be deemed an original, but both of which together shall constitute one and the same instrument. This Agreement shall become binding when one or both counterparts hereof, individually or taken together, shall bear the signatures of the Parties.

10.15 Incorporation of Recitals.

The Parties incorporate the recitals into this Agreement as representations of fact to each other.

IN WITNESS WHEREOF, the undersigned parties have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.

CONTRACTOR	**COMPANY**
By:	_____
_	By:_____
Printed Name: _____	Printed Name: _____
Title: _____	Title: _____
Date: _____	Date:_____

PROGRAM PARTICIPATION SCHEDULE

Contractor agrees to participate in the Plans and other health benefit programs listed herein:
Those Medicaid Plans and programs offered by Company within the State of _____ [Identify State].

SERVICES AND COMPENSATION SCHEDULE

[Placeholder]

EXHIBIT A – Subcontractor Regulatory Compliance Addendum

[Placeholder]

Medical Services Provider Agreement

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MEDICAID CONTRACTOR AGREEMENT

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Program Participation Schedule
Services and Compensation Schedule
Contractor Regulatory Compliance Addendum

[Note: To the extent applicable, add the following (and/or other) exhibits.**]**

Provider Regulatory Compliance Addendum
Delegated Claims Addendum
Delegated Credentialing Addendum
Delegated Patient Management Addendum
Delegated Quality Management Addendum
Delegated Customer Service Addendum
[Other]

MEDICAID CONTRACTOR AGREEMENT

This Medicaid Contractor Agreement, together with all exhibits and attachments hereto (collectively, the "Agreement") is made and entered into as of _____ [Identify Effective Date] ("Effective Date") by and between _____ [Identify name of the specific health plan], a _____ [Identify name of State] corporation, on behalf of itself and its Affiliates (hereinafter "Company"), and _____ [Identify Provider] (hereinafter "Provider"). A **Contractor Regulatory Compliance Addendum** is attached to this Agreement and is binding upon the Parties. In the event of any inconsistent or contrary language between the **Contractor Regulatory Compliance Addendum** and any other part of this Agreement, including, but not limited to, any other exhibits, attachments, schedules or amendments, the provisions of the **Contractor Regulatory Compliance Addendum** shall prevail.

WHEREAS, Company administers Plans for Government Sponsors that provide access to health care services to Members or arranges for the provision of health care services to Members of Government Programs; and

WHEREAS, Company contracts with certain health care providers to provide access to such health care services to Members; and

WHEREAS, Provider has established a network of service providers ("Subcontracted Providers"), under contract with Provider, to provide Provider Services to Members; and

WHEREAS, Company and Provider mutually desire to enter into an arrangement whereby Provider, through its Subcontracted Providers, will provide and arrange for the provision of covered Provider Services (hereinafter, the "Covered Services") to Members; and

[**Note:** To the extent applicable, identify those services delegated to Provider in the following recital clause.]

WHEREAS, Company shall delegate to Provider [claims], [credentialing], [patient management], [quality management], and [customer service], which duties and obligations of the Parties related to such delegated services are set forth in the [Delegated Claims Addendum], [Delegated Credentialing Addendum], [Delegated Patient Management Addendum], [Delegated Quality Management Addendum], [Delegated Customer Service Addendum] attached hereto and made a part of this Agreement hereof; and

WHEREAS, in return for the provision of Covered Services by Provider, Company will provide payment to Provider for Covered Services in accordance with the terms of this Agreement.

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants, promises and undertakings herein, the sufficiency of which is hereby acknowledged, and intending to be legally bound hereby, the parties agree as follows:

1.0 DEFINITIONS

When used in this Agreement, all capitalized terms shall have the following meanings:

1.1 Affiliate. Any corporation, partnership or other legal entity (including any Plan) directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with either party to this Agreement.

1.2 Confidential Information. Any information that identifies a Member and is related to the Member's participation in a Plan, the Member's physical or mental health or condition, the provision of health care to the Member or payment for the provision of health care to the Member. Confidential Information includes, without limitation, "individually identifiable health information," as defined in 45 C.F.R. § 160.103 and "non-public personal information" as defined in laws or regulations promulgated under the Gramm-Leach-Bliley Act of 1999, as applicable. Confidential Information may be referred to as "Member Confidential Information."

1.3 Copayment. A charge required under a Plan that must be paid by a Member at the time of the provision of Covered Services, or at such other time as determined by Provider.

1.4 Covered Services. Those Provider Services provided by Subcontracted Provider for which a Member is entitled to receive coverage under the terms and conditions of a Plan.

1.5 Deductible. An amount that a Member must pay for Covered Services during a specified coverage period in accordance with the Member's Plan before benefits will be paid.

1.6 Effective Date. Defined in first paragraph of this Agreement.

1.7 Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, her pregnancy or health or the health of her fetus) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part; or such other definition as may be required by applicable law.

1.8 Emergency Services. Covered Services furnished by a qualified provider and necessary to evaluate or stabilize an Emergency Medical Condition.

1.9 Government Programs. Plans operated and/or administered by Company pursuant to a State Contract.

1.10 Government Sponsor. A state agency or other governmental entity authorized to offer, issue and/or administer one or more Plans, and which, to the extent applicable, has contracted with Company to administer all or a portion of such Plan(s).

1.11 Member. An individual covered by or enrolled in a Plan and entitled to such Covered Services offered by the Plan.

1.12 Party. Company or Provider, as applicable.

1.13 Plan. A Member's health care benefits as set forth in the State Contract. Such Plans are listed in the **Program Participation Schedule** attached hereto and made a part hereof.

1.14 Policies. The policies and procedures promulgated by Company (and, where applicable, Government Sponsor) which relate to the duties and obligations of the Parties under the terms of this Agreement, including, but not limited to: (a) quality improvement/management; (b) utilization management, including, but not limited to, precertification of elective admissions and procedures, concurrent review of services and referral processes or protocols; (c) pre-admission testing guidelines; (d) claims payment review; (e) member grievances; (f) provider credentialing; (g) electronic submission of claims and other data required by Company; and (h) any applicable participation criteria required by the State in connection with the Government Programs. Policies also include those policies and procedures set forth in the Company's and/or Government Sponsor's manuals (as modified from time to time) as Company determines appropriate in its sole discretion; clinical policy bulletins made available via Company's internet web site; and other policies and procedures, whether made available via a password-protected web site for Provider and/or Subcontracted Provider (when available), by letter, newsletter, electronic mail or other media.

1.15 Proprietary Information. Any and all information, whether prepared by a Party, its advisors or otherwise, relating to such Party or the development, execution or performance of this Agreement whether furnished prior to or after the Effective Date. Notwithstanding the foregoing, the following shall not constitute Proprietary Information:

(a) information which was known to a receiving Party (a "Recipient") prior to receipt from the other Party (a "Disclosing Party") (as evidenced by the written records of a Recipient);
(b) information which was previously available to the public prior to a Recipient's receipt thereof from a Disclosing Party;
(c) information which subsequently became available to the public through no fault or omission on the part of a Recipient, including without limitation, the Recipient's officers, directors, trustees, employees, agents, contractors and other representatives;
(d) information which is furnished to a Recipient by a third party which a Recipient confirms, after due inquiry, has no confidentiality obligation, directly or indirectly, to a Disclosing Party; or
(e) information which is approved in writing in advance for disclosure or other use by a Disclosing Party.

1.16 Provider Services. Services covered by the Plan, certain of which covered services may be identified in the

Services and Compensation Schedule attached hereto and made a part of this Agreement hereof.. Such services shall also be referred to as "Covered Services."

1.17 Related Parties. A party's parent, subsidiary, other Affiliate, or any of their respective officers, directors, trustees, employees, agents, contractors, subcontractors or other representatives.

1.18 State Contract. Company's contract(s) with Government Sponsors to administer Plans or Government Programs identified in the **Program Participation Schedule**.

1.19 Subcontracted Provider. A service provider under contract with Provider to provide Covered Services to Members.

2.0 PROVIDER SERVICES AND OBLIGATIONS

2.1 Provision of Services.
Provider will make available and provide to Members those Covered Services in the service areas covered by the State Contract and this Agreement, as set forth in the **Services and Compensation Schedule**.

2.2 Non-Discrimination

2.2.1 Equitable Treatment of Members. Provider agrees to provide, and cause Subcontracted Providers to provide, Covered Services to Members with the same degree of care and skill as customarily provided to Provider's clients who are not Members ("non-Members"), according to generally accepted standards of practice. Provider and Company agree that Members and non-Members should be treated equitably; to that end, Provider agrees not to discriminate against Members on the basis of race, gender, creed, ancestry, lawful occupation, age, religion, marital status, sexual orientation, mental or physical disability, color, national origin, place of residence, health status, source of payment for services, cost or extent of Covered Services required, or any other grounds prohibited by law or this Agreement.

2.2.2 Affirmative Action. Company is a Federal contractor and an Equal Opportunity Employer which maintains an Affirmative Action Program. To the extent applicable to Provider, Provider agrees to comply with the following, as amended from time to time: Executive Order 11246, the Vietnam Era Veterans Readjustment Act of 1974, the Drug Free Workplace Act of 1988, Section 503 of the Rehabilitation Act of 1973, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") administrative simplification rules at 45 CFR parts 160, 162, and 164, Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b) of the Social Security Act), and any similar laws, regulations or other legal mandates applicable to transactions under or otherwise subject to any government contract of Company.

2.3 Party Representations.

2.3.1 General Representations. As set forth herein, Provider represents, warrants and covenants (and shall require each Subcontracted Provider to represent, warrant and covenant) and/or Company represents, warrants and covenants, as applicable, that the following: (a) Provider and Company have and shall maintain throughout the term of this Agreement all applicable license(s) and certification(s) mandated by governmental regulatory agencies; (b) Provider and Company are, and will remain throughout the term of this Agreement, in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided hereunder, including, without limitation, statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, false claims and prohibition of kickbacks; (c) if, during the course of providing services to Members enrolled in a Plan and/or any other Government Program, a Government Sponsor or CMS requires Provider (and/or each of its Subcontracted Providers) to become certified to participate in such programs for which Provider and/or each Subcontracted Provider is not yet certified (the "Government Certification"), then Provider shall either exercise best efforts to obtain such Government Certification (and to require each of its Subcontracted Providers to do so) within that period of time as required by the Government Sponsor or CMS, or, in the event that Provider determines that it will not pursue such requisite Government Certification (and/or Provider is not able to obtain the requisite Government Certification within that period of time as required by the Government Sponsor or CMS), then Provider shall cease from providing services to Members enrolled in Company's Plan or other Company Government Program upon such date as mutually agreed to by the parties (provided, however, that such date is not violative of any Government Sponsor or CMS directive or applicable laws) and Provider shall cooperate with Company in the transitioning of such Member care, where applicable, in accordance with the terms of this Agreement and in accordance with all applicable laws (including, but not limited to, those laws concerning written notice to Members of Provider's non-par status upon a certain effective date); (d) Provider has established an ongoing quality assurance/assessment program that includes, but is not limited to, appropriate credentialing of employees and subcontractors and shall supply to Company, if requested by Company, the relevant documentation, including, but not limited to, internal quality assurance/assessment protocols, state licenses and certifications, Federal agency certifications and/or registrations upon request; (e) all Provider personnel employed by, associated or contracted with Provider, including, in part, Subcontracted Providers who provide or arrange for the provision of Covered Services to Members: (i) are and will remain throughout the term of this Agreement appropriately licensed and/or certified (when and as required by state law) and, as applicable, properly supervised (when and as required by law), (ii) are qualified by education, training and experience to perform their professional duties, (iii) will act within the scope of their licensure or certification, as the case may be, and (iv) will fully comply, at all times, with Provider's Subcontracted Provider guidelines, policies and procedures; (f) where applicable, its credentialing, privileging, and re-appointment procedures are in accordance with its policies and procedures and fulfill all applicable state and Federal standards; (g) Provider shall require the Subcontracted Providers to comply with the applicable terms of this Agreement; (h) this Agreement has been executed by duly authorized representative of Provider and Company; (i) executing this Agreement and performing its obligations hereunder shall not cause Provider or Company to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed; and (j) Provider shall ensure that appropriate oversight as it concerns each of its Subcontracted Providers.

Notwithstanding the foregoing representations, the Parties understand and agree that Company shall have the right, on an on-going basis, to review and approve Provider's Subcontracted Provider selection criteria, which approval by Company shall not be

unreasonably withheld. Company shall have the right to disapprove of any Subcontracted Provider, provided that such right shall be exercised reasonably.

2.3.2 Government Program Representations. Company has or may seek a contract to serve beneficiaries ("Government Programs"). To the extent Company participates in such Government Programs, Provider agrees, on behalf of itself and any subcontractors of Provider, to be bound by all rules and regulations of, and all requirements applicable to, such Government Programs. Provider acknowledges and agrees that all provisions of this Agreement shall apply equally to any employees, independent contractors and subcontractors of Provider who provide or may provide services to Members of Government Programs, and Provider represents and warrants that Provider shall comply, and shall take all steps necessary to cause such employees, independent contractors and subcontractors to comply, with the Agreement and all Applicable Laws, and perform all requirements applicable to Government Programs. With respect to Members of Government Programs, Provider acknowledges that compensation under this Agreement for such Members constitutes receipt of Federal funds. Provider agrees that all services and other activities performed by Provider under this Agreement will be consistent and comply with Company's obligations under its contract(s) with the Government Sponsor, and any applicable state regulatory agency, to offer Government Program Plans. Provider further agrees to allow CMS, the Government Sponsor, any applicable state regulatory agency, and Company to monitor Provider's performance under this Agreement on an ongoing basis in accordance with applicable laws, rules and regulations. Provider acknowledges and agrees that Company may only delegate its activities and responsibilities under its contract(s) with the Government Sponsor and any applicable regulatory agency, to offer Government Program Plans in a manner consistent with applicable laws, rules and regulations, and that if any such activity or responsibility is delegated by Company to Provider, the activity or responsibility may be revoked if CMS, the Government Sponsor or Company determine that Provider has not performed satisfactorily.

2.3.3 Provider represents and warrants, and shall require each of the Subcontracted Providers to warrant, that neither it nor any of its Related Parties who is and/or will be fully or partially responsible for Provider's performance of its obligations under this Agreement has (i) pled guilty or no contest to or been convicted of any felony involving dishonesty or breach of trust; or (ii) been excluded from participation in any federal- or state-funded health program; or (iii), where applicable, been listed in the National Practitioner Data Bank or the Healthcare Integrity and Protection Data Bank (each a "Data Bank"). In the event Provider or any of Provider's Related Parties has an adverse action report listed in a Data Bank after the Effective Date, and, in the case a Related Party is listed, Provider fails to terminate such Related Party's role in providing of services under this Agreement immediately upon learning of such fact, Company shall have the right, in its sole discretion and judgment, to terminate the Agreement as provided in Section 6.4 herein or to disqualify the listed person(s) from providing any part of the Services.

2.4 Provider's Insurance.

During the term of this Agreement, Provider shall procure and maintain, with respect to the activities in which Provider and its employees engage pursuant to this Agreement, such policies of general and professional liability and other insurance at minimum levels required from time to time by Company, but in no event less than: (a) professional liability insurance at a minimum level of $1 million per claim, $3 million annual aggregate; and (b) comprehensive general liability insurance at a minimum level of $1 million per claim $3 million annual aggregate. Such insurance coverage shall cover the acts and omissions of Provider, and each of Provider's employees. Provider agrees to deliver memorandum copies of such policies to Company upon request. Provider agrees to make

best efforts to provide to Company at least thirty (30) days advance notice, and in any event will provide notice as soon as reasonably practicable, of any cancellation or material modification of said policies.

In addition to the above, Provider shall require and ensure that each Subcontracted Provider shall maintain throughout the term of this Agreement professional liability insurance, comprehensive general liability insurance and automobile liability insurance in those amounts that are reasonable (but in no event less than the amounts required by applicable law) in light of those services, including Covered Services, provided by Subcontracted Provider, to Company Members.

2.5 Subcontracted Provider Information

Provider shall provide to Company a complete list of Subcontracted Providers, including any unique names, office addresses, telephone and facsimile numbers. Provider shall notify Company in writing within ten (10) business days of any changes to this information including, but not limited to, any additional Subcontracted Providers that joined Provider's provider network.

2.6 Subcontracted Provider Agreements

Notwithstanding any contrary interpretation of this Agreement or any contracts between Provider and Subcontracted Providers, Provider acknowledges and agrees that all provisions of this Agreement applicable to Provider shall apply with equal force to Subcontracted Providers, unless clearly applicable only to Provider. Provider agrees that it is Provider's responsibility to require Subcontracted Providers to fully comply with their obligations under this Agreement , and that Provider will take all steps necessary to enforce such requirements and to cause Subcontracted Providers to comply with and perform the terms and conditions of this Agreement.

2.7 Product Participation.

Provider agrees to participate in the Plans and other health benefit products listed on the **Program Participation Schedule** attached hereto and made a part hereof. The parties may mutually agree in writing to increase or decrease the types of Covered Services made available to Members under this Agreement, subject to the approval of the Government Sponsor.

Nothing herein shall require that Company identify, designate or include Provider as a preferred participant in any specific Plan or product.

2.8 Consents to Release Medical Information.

Where applicable, Provider covenants that it will obtain from Members to whom Covered Services are provided, any necessary consents or authorizations to the release of Information and Records to Company, its agents and representatives in accordance with any applicable Federal or state law or regulation or this Agreement.

2.9 Off-Shoring of Services.

In no event shall Provider, without Company's prior written approval, perform any services under the Agreement through any individual or entity (including, but not limited to, any employee, Provider, subcontractor, agent, representative or other individual or entity), if such individual or entity is physically located outside of one of the fifty United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands) ("Offshore Entity"). Provider further agrees that Provider may not utilize the services of any Offshore Entity not audited by Company prior to the provision of services.

In the event that Company provides Provider with prior written approval to use an Offshore Entity to perform any services for Plans, Provider shall take all steps necessary to ensure that: (a) Offshore Entity complies with the requirements of this Agreement and any related amendment, and (b)

Provider and Offshore Entity comply with all laws, rules and regulations, including, without limitation, CMS instructions, applicable to the performance of any services for Plans outside of one of the fifty United States or one of the United States Territories.

In no event shall Provider, without Company's prior written approval, provide Protected Health Information (as that term is defined below) received from, or created or received by Provider on behalf of Company, to any employee or agent, including a subcontractor, if such employee, agent or subcontractor receives, processes or otherwise has access to the Protected Health Information outside of the United States of America. 'Protected Health Information' shall have the same meaning as the term 'Protected Health Information,' as defined by 45 C.F.R. 160.103, limited to the information created or received by Delegated Entity from or on behalf of Company.

3.0 COMPANY OBLIGATIONS

3.1 Company's Covenants.
Company shall provide Members with a means to identify themselves to Provider (e.g., identification cards), and a general description of products. Company shall provide Provider with a means to check eligibility, including providing Provider with eligibility files in a HIPAA-compliant electronic format at least prior to the 2nd day of each month under this Agreement. Company will use best efforts to assure the accuracy and currency of that information.

3.2 Company Representations.
Company represents and warrants that: (a) it, where applicable, is licensed to offer, issue and administer Plans in the service areas covered by this Agreement by the applicable regulatory authority ("License"); (b) it will not lose such License involuntarily during the course of this Agreement; (c) it is, and will remain throughout the term of this Agreement, substantially in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided hereunder; including without limitation, any applicable prompt payment statutes and regulations or capital reserve requirements; provided however, that for the purposes of (b) and (c), Provider will have no basis for termination to the extent that such action does not impact the obligations of Company under this Agreement; (d) this Agreement has been executed by its duly authorized representative; and (e) executing this Agreement and performing its obligations hereunder shall not cause Company to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

4.0 COMPENSATION; MEMBER BILLING

4.1 Compensation.
Company shall provide Compensation to Provider for Covered Services provided to Members in accordance with the terms of the **Services and Compensation Schedule**, which is attached hereto and made a part of this Agreement hereof.

To the extent that Company delegates, to Provider, any services under this Agreement (whereby the terms of such delegated services arrangements are set forth in unique delegation addenda attached to this Agreement), Provider understands and agrees that no additional compensation shall be payable to Provider for such delegated services in addition to the compensation set forth in the **Services and Compensation Schedule** to this Agreement.

4.2 Member Billing.
Provider may bill or charge Members only in the following circumstances: (a) applicable

Copayments, Coinsurance and/or Deductibles, if any, not collected at the time that Covered Services are rendered; and (b) for services that are not Covered Services only if: (i) the Member's Plan provides and/or Company confirms that the specific services are not covered; (ii) the Member was advised in writing prior to the services being rendered that the specific services may not be Covered Services; and (iii) the Member agreed in writing to pay for such services after being so advised. Provider acknowledges that Company's denial or adjustment of payment to Provider based on Company's performance of utilization management or otherwise is not a denial of Covered Services under this Agreement or under the terms of a Plan, except if Company confirms otherwise. Provider may bill or charge individuals who were not Members at the time that services were rendered.

Provider hereby agrees that in no event, including, but not limited to the failure, denial or reduction of payment by Company, insolvency of Company or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse (i) against Members or persons acting on their behalf (other than Company) or (ii) any settlement fund or other *res* controlled by or on behalf of, or for the benefit of, a Member for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance, Deductibles made in accordance with the terms of the applicable Plan. Provider further agrees that this Section 4.2: (a) shall survive the expiration or termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) supersedes any oral or written contrary agreement or waiver now existing or hereafter entered into between Provider and Members or persons acting on their behalf.

To protect Members, Provider agrees not to seek or accept or rely upon waivers of the Member protections provided by this Section 4.2.

5.0 COMPLIANCE WITH POLICIES

5.1 Policies.

Provider agrees to comply with Policies. Neither party may modify the Policies without the prior written consent of the other party (which consent shall not be unreasonably withheld or delayed); provided, however, either party may modify the Policies to comply with applicable Mandates upon at least thirty (30) days' prior written notice to the other party. Notwithstanding the foregoing, either party may object to such proposed modification during the thirty-day notice period in the event that such objecting party reasonable believes, and provides a full explanation in support of the fact, that such proposed modification will have a material adverse financial impact upon such party; provided, further, at that time, the parties will negotiate in good faith an appropriate modification to the Policies (taking into consideration each party's interpretation of the subject Mandate(s) and the subject parties' concerns with regard to the proposed modification); provided, further, in the event the parties are unable to agree to any such modification to the Policies within that thirty-day notice period, then either party may terminate this Agreement upon written notice to the other party, which effective date of termination shall be at least one hundred eighty (180) days following the receipt of such written notice of termination. During the aforementioned one hundred eighty (180) day period, the subject Policy shall remain in its original form and not be modified unless any such regulatory agency and/or accreditation body expressly directs (either in direct response to an inquiry from either party to this Agreement or by any other means) the effectuation of such modification during the remaining one hundred eighty (180) days of the Agreement.

5.2 Notices and Reporting.

To the extent neither prohibited by law nor violative of applicable privilege, Provider agrees to provide notice to Company, and shall provide all information reasonably requested by Company

regarding the nature, circumstances, and disposition, of: (a) any litigation brought against Provider or any of its employees, that is related to the provision of Provider Services and could have a material impact on the Covered Services provided to Members; (b) any investigation initiated by any government agency or program against or involving Provider or any of its employees that does or could materially impact and/or adversely affect Provider's licensure, or certification to participate in the Medicare, Medicaid or other Government Programs; (c) any change in the ownership or management of Provider other than a change in which beneficial ownership and control remains with the existing owners, directors, or officers; and (d) any material change in services provided by Provider and Subcontracted Providers or licensure status related to such services that has a material impact on the delivery of services under this Agreement. Provider agrees to use best efforts to provide Company with prior notice of, and in any event will provide notice as soon as reasonably practicable notice of, any actions taken by Provider described in this Section 5.2.

5.3 Information and Records.

5.3.1 Maintenance of Information and Records. Provider agrees (a) to maintain Information and Records (as such terms are defined in Section 5.3.2) in a current, detailed, organized and comprehensive manner and in accordance with customary practice, applicable Federal and state laws, and accreditation standards; (b) that all Member medical records and Confidential Information shall be treated as confidential and in accordance with applicable laws; (c) to maintain such Information and Records for the longer of six (6) years after the last date Provider Services were provided to Members, or the period required by applicable laws, rules or regulations. This Section 5.3.1 shall survive the termination of this Agreement, regardless of the cause of the termination.

5.3.2 Access to Information and Records. Provider agrees that (a) Company (including Company's authorized designee) shall have access to all data and information obtained, created or collected by Provider related to Members relevant to this Agreement and necessary for payment of claims, including, without limitation, Confidential Information ("Information"); (b) Company (including Company's authorized designee) and Federal, state, and local governmental authorities and their agents having jurisdiction, upon request, shall have access, for any reasonable purpose under the terms of this Agreement, to all books, records and other papers (including, but not limited to, contracts and medical and financial records) and information relating to this Agreement and to those services rendered by Provider to Members ("Records"); (c) consistent with the consents and authorizations required by Section 2.8 hereof, Company or its agents or designees shall have access to Member Records for the purpose of assessing quality of services, conducting audits, and, where applicable, performing utilization management functions; (d) applicable Federal and state authorities and their agents shall have access to Records for assessing the quality of services or investigating Member grievances or complaints; and (e) where applicable, Members shall have access to their health information as required by 45 C.F.R. § 164.524 and applicable state law, be provided with an accounting of disclosures of information when and as required by 45 C.F.R. § 164.528 and applicable state law, and have the opportunity to amend or correct the information as required by 45 C.F.R. § 164.526 and applicable state law. Provider agrees to supply copies of Information and Records within fourteen (14) days of the receipt of a request, where practicable, and in no event later than the date required by any applicable law or regulatory authority. This Section 5.3.2 shall survive the termination of this Agreement, regardless of the cause of termination.

5.4 Accreditation and Review Activities.
Provider agrees to cooperate with any review of Company or a Plan conducted by the National

Committee for Quality Assurance (NCQA) or a state or Federal agency with authority over Company and/or the Plan, as applicable.

5.5 Proprietary Information; Rights and Responsibilities. Each Party agrees that the Proprietary Information of the other Party is the exclusive property of such Party and that each Party has no right, title or interest in the same. Each Party agrees to keep the Proprietary Information and this Agreement strictly confidential and agrees not to disclose any Proprietary Information or the contents of this Agreement to any third party, except to governmental authorities having jurisdiction and, in the case of Company's disclosure, to Members, consultants and vendors under contract with Company, or as otherwise directed by the other Party. Except as otherwise required under applicable Federal or state law, each Party agrees to not use any Proprietary Information of the other Party, and at the request of the other Party hereto, return any Proprietary Information upon termination of this Agreement for whatever reason. This Section 5.5.1 shall survive the termination of this Agreement for one (1) year, regardless of the cause of termination.

6.0 TERM AND TERMINATION

6.1 Term.
This Agreement shall be effective for an initial term of [Identify Initial Term Period] (___) years from the Effective Date (the "Initial Term"), and thereafter shall automatically renew for subsequent additional terms of one (1) year each, unless and until terminated in accordance with this Article 6.0.

6.2 Termination without Cause.
This Agreement may be terminated without cause at any time by either Party upon at least one hundred eighty (180) days prior written notice to the other Party; provided, however, Provider may not terminate this Agreement without cause during the Initial Term of this Agreement.

6.3 Termination for Breach.
This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party upon material default or substantial breach by such Party of one or more of its obligations hereunder, unless such material default or substantial breach is cured within sixty (60) days of the notice of termination; provided, however, if such material default or substantial breach is incapable of being cured within such sixty (60) day period, any termination pursuant to this Section 6.3 will be ineffective for the period reasonably necessary to cure such breach if the breaching party has taken all steps reasonably capable of being performed within such sixty (60) day period. Notwithstanding the foregoing, (a) in the event the material breach is nonpayment by Company of material amounts due Provider hereunder, Provider may terminate this Agreement upon thirty (30) days prior written notice of such termination, unless such breach is cured within thirty (30) days of the notice of termination and (b) the effective date of such termination may be extended pursuant to Section 6.6 herein.

6.4 Immediate Termination or Suspension.
Any of the following events shall result in the immediate termination or suspension of this Agreement by Company, upon notice to Provider, at Company's discretion at any time: (a) the withdrawal, expiration or non-renewal of any Federal, state or local license, certificate, approval or authorization of Provider the loss of which has a material impact on Provider's performance of this Agreement; (b) the bankruptcy or receivership of Provider, or an assignment by Provider for the benefit of creditors; (c) the loss or material limitation of Provider's insurance; (d) a reasonable determination by Company that Provider's continued provision of Services could result in harm to Members and that such potential harm cannot be avoided by other means, such as the termination of

a Subcontracted Provider; (e) the debarment or suspension of Provider or any of Provider's Related Parties from participation in any governmental sponsored program, including, but not limited to, Government Programs, Medicaid and Medicare and, in the case a Related Party is debarred or suspended, Provider fails to terminate such Related Party's role in providing of services under this Agreement immediately upon learning of such fact; (f) the conviction of Provider for any felony; (g) the revocation or suspension of Provider's accreditation by any applicable accrediting agency recognized by Company; (h) change of control of Provider to an entity not acceptable to Company, other than a change in which beneficial ownership and control remains in the then existing owners, directors, or officers.; or (i) any fraud by Provider or Provider's Related Parties and, in the case such fraud is perpetrated by a Related Party, Provider fails to terminate such Related Party's role in providing of services under this Agreement immediately upon learning of such fraud. To protect the interests of Members, Provider will provide immediate notice to Company of any of the aforesaid events, including notification of impending bankruptcy. Upon Company's request, Company shall provide all known details of the nature, circumstances, and disposition of any suits, claims, actions, investigations or listings to Company.

Any of the following events shall result in the immediate termination or suspension of this Agreement by Provider, upon notice to Company, at Provider's discretion at any time: (a) the withdrawal, expiration or non-renewal of any Federal, state or local license, certificate, approval or authorization of Company the loss of which has a material impact on Contractor's performance of this Agreement; (b) the bankruptcy or receivership of Company, or an assignment by Company for the benefit of creditors; (c) the conviction of Company for any felony; or (d) change of control of Company to an entity not acceptable to Provider. Company will provide immediate notice to Provider of any of the aforesaid events, including notification of impending bankruptcy. Upon Provider's request, Provider shall provider all known details of the nature, circumstances, and disposition of any suits, claims, actions, investigations or listings to Company.

6.5 Obligations Following Termination.
Upon notice of expiration or termination of this Agreement or of a Plan, Provider shall cooperate with Company and comply with Policies, if any, in the transfer of Members to other service vendors providing Provider Services.

6.6 Obligations During Dispute Resolution Proceedings.
In the event of any dispute between the Parties in which a Party has provided notice of termination under Section 6.3 and the dispute is required to be resolved or is submitted for resolution under Article 8.0 below, the termination of this Agreement shall be stayed and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

7.0 RELATIONSHIP OF THE PARTIES

7.1 Independent Contractor Status; Indemnification.
The relationship between Company and Provider, as well as their respective employees and agents, is that of independent contractors, and neither shall be considered an agent or representative of the other party for any purpose, nor shall either hold itself out to be an agent or representative of the other for any purpose. The parties hereby agree to indemnify and hold each other harmless, including any Affiliates, officers, employees and agents, against any loss, liability, damage, costs and expenses (including any attorneys' fees) suffered or incurred by the other in connection with any (including any threatened or proposed) action, suit, proceeding, regulatory proceeding, demand, assessment, judgment arising out of or related to the indemnifying party's and/or the indemnifying party's agent's acts and/or omissions under the terms of this Agreement. This provision shall survive the expiration or termination of this Agreement, regardless of the reason for

termination.

7.2 Use of Name.
Provider consents to the use of Provider's name and other, non-trademark, identifying and descriptive material in provider directories and in other materials and marketing literature of Company in all formats, including, but not limited to, electronic media. Provider may use Company's names, logos, trademarks or service marks in marketing materials or otherwise, upon receipt of Company's prior written consent, which shall not be unreasonably withheld.

7.3 Interference with Contractual Relations.
Provider shall not engage in activities with the intent of causing Company to lose existing or potential Members, and shall not: (a) advise Company customers, Plan Sponsors or other entities currently under contract with Company to cancel, or not renew said contracts; (b) directly impede or interfere with negotiations which Company is conducting for the provision of health benefits or Plans; or (c) use or disclose to any third party membership lists acquired during the term of this Agreement for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this Section 7.3 is intended or shall be deemed to restrict (i) any communication between Provider and a Member determined by Provider to be necessary or appropriate for the provision of Services. This Section shall continue to be in effect for a period of one (1) year after the expiration or termination of this Agreement. Company shall not (a) advise Provider customers, Plan Sponsors or other entities currently under contract with Provider or its affiliates to cancel, or not renew said contracts; (b) use or disclose to any third party membership or provider lists acquired during the term of, and solely pursuant to, this Agreement for the purpose of soliciting individuals who were or are Members or Providers or otherwise to compete with Company.

8.0 DISPUTE RESOLUTION

8.1 Member Grievance Dispute Resolution.
Provider agrees to (a) cooperate with and participate in Company's applicable appeal, grievance and external review procedures (including, but not limited to, Government Program appeals and expedited appeals procedures), (b) provide Company with the information necessary to resolve same, and (c) abide by decisions of the applicable appeals, grievance and review committees.

8.2 Dispute Resolution.
The parties shall attempt in good faith to resolve any dispute arising out of or relating to this Agreement promptly by negotiation between executives who have authority to settle the controversy. If such dispute is not resolved in the normal course of business, then either party may provide written notice of the outstanding dispute to the other party (consistent with the terms of this Section 8.2 as set forth herein). Within (15) days after delivery of the notice, the receiving party shall submit to the other a written response. The notice and the response shall include (a) a statement of each party's position and a summary of arguments supporting that position, and (b) the name and title of the executive who will represent that party and of any other person who will accompany the executive. Within (30) days after delivery of the disputing party's notice, the executives of both parties shall meet at a mutually convenient time and place, and thereafter as often as they reasonably deem necessary, to attempt to resolve the dispute. All reasonable requests for information made by one party to the other will be honored. All negotiations pursuant to this provision are confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rues of evidence. If the dispute is not resolved by negotiation between executives, then either party may institute arbitration in accordance with Section 8.3 of this Agreement. Discussions and negotiations held pursuant to this Section 8.2 shall be treated as

inadmissible compromise and settlement negotiations for purposes of applicable rules of evidence.

8.3 Arbitration.

8.3.1 Submission of Claim or Controversy to Arbitration. Any controversy or claim arising out of or relating to this Agreement or the breach, termination, or validity thereof, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration administered by the American Arbitration Association ("AAA") and conducted by a sole Arbitrator ("Arbitrator") in accordance with the AAA's Commercial Arbitration Rules ("Rules"). The arbitration shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16, to the exclusion of state laws inconsistent therewith or that would produce a different result, and judgment on the award rendered by the Arbitrator (the "Award") may be entered by any court having jurisdiction thereof. A stenographic record shall be made of all testimony in any arbitration in which any disclosed claim or counterclaim exceeds $250,000. An Award for $250,000 or more shall be accompanied by a short statement of the reasoning on which the Award rests.

8.3.2 Appeal of Arbitration Award. In the event a Party believes there is a clear error of law and within thirty (30) days of receipt of an Award of $250,000 or more (which shall not be binding if an appeal is taken), a Party may notify the AAA of its intention to appeal the Award to a second Arbitrator (the "Appeal Arbitrator"), designated in the same manner as the Arbitrator except that the Appeal Arbitrator must have at least twenty (20) years' experience in the active practice of law or as a judge. The Award, as confirmed, modified or replaced by the Appeal Arbitrator, shall be final and binding, and judgment thereon may be entered by any court having jurisdiction thereof. No other arbitration appeals may be made.

8.3.3 Confidentiality. Except as may be required by law or to the extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an Award, neither a Party nor an arbitrator may disclose the existence, content, record, status or results of a negotiation or arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to a negotiation or arbitration, or reflecting the existence, content, record, status, or results of a negotiation ("Negotiation Record") or arbitration ("Arbitration Record"), is confidential. The arbitration hearing shall be closed to any person or entity other than the arbitrator, the parties, witnesses during their testimony, and attorneys of record. Upon the request of a Party, an arbitrator may take such actions as are necessary to enforce this Section 8.3.3, including the imposition of sanctions.

8.3.4 Pre-hearing Procedure for Arbitration. The Parties will cooperate in good faith in the voluntary, prompt and informal exchange of all documents and information (that are neither privileged nor proprietary) relevant to the dispute or claim, all documents in their possession or control on which they rely in support of their positions or which they intend to introduce as exhibits at the hearing, the identities of all individuals with knowledge about the dispute or claim and a brief description of such knowledge, and the identities, qualifications and anticipated testimony of all experts who may be called upon to testify or whose report may be introduced at the hearing. The Parties and Arbitrator will make commercially reasonable efforts to conclude the document and information exchange process within sixty (60) calendar days after all pleadings or notices of claims have been received. At the request of a Party in any arbitration in which any disclosed claim or counterclaim exceeds $250,000, the Arbitrator may also order pre-hearing discovery by deposition upon good cause shown. Such depositions shall be limited to a maximum of three (3) per Party and shall be limited to a maximum of six (6) hours' duration each. As they become aware of new documents or information (including experts who may be called upon to testify), all Parties remain under a

continuing obligation to provide relevant, non-privileged documents, to supplement their identification of witnesses and experts, and to honor any understandings between the Parties regarding documents or information to be exchanged. Documents that have not been previously exchanged, or witnesses and experts not previously identified, will not be considered by the Arbitrator at the hearing. Fourteen (14) calendar days before the hearing, the Parties will exchange and provide to the Arbitrator (a) a list of witnesses they intend to call (including any experts) with a short description of the anticipated direct testimony of each witness and an estimate of the length thereof, and (b) premarked copies of all exhibits they intend to use at the hearing.

8.3.5 Arbitration Award. The arbitrator may award only monetary relief and is not empowered to award damages other than set forth in this Agreement. The Award shall be in satisfaction of all claims by all Parties. Arbitrator fees and expenses shall be borne equally by the Parties. Postponement and cancellation fees and expenses shall be borne by the Party causing the postponement or cancellation. Fees and expenses incurred by a Party in successfully enforcing an Award shall be borne by the other Party. Except as otherwise provided in this Agreement, each Party shall bear all other fees and expenses it incurs, including all filing, witness, expert witness, transcript, and attorneys' fees.

8.3.6 Survival. The provisions of Section 8.3 shall survive expiration or termination of this Agreement, regardless of the cause giving rise hereto.

8.4 Arbitration Solely Between Parties; No Consolidation or Class Action.
Company and Provider agree that any arbitration or other proceeding related to a dispute arising under this Agreement shall be conducted solely between them. Neither Party shall request, nor consent to any request, that their dispute be joined or consolidated for any purpose, including without limitation any class action or similar procedural device, with any other proceeding between such Party and any third party.

9.0 CONFIDENTIALITY OF MEMBER INFORMATION, HIPAA AND GLBA COMPLIANCE

9.1 Confidentiality, HIPAA and GLBA. Provider and Company agree that confidentiality of Member medical information must be safeguarded. Provider agrees to ensure that any information related to a Member is to be kept strictly confidential in accordance with all state and federal laws regarding, among other things, the confidentiality of patient records and shall not be released to any third party except as set forth in Article 5 and this Article 9 of the Agreement. According to the terms of Company's HMO enrollment forms, agreements with Members and applicable law, Company shall be able to obtain Member information from Provider without additional written release by the Member. Each party agrees to comply with all applicable requirements of TITLE II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 and its related regulations ("HIPAA"), including any and all requirements regarding the privacy and security of protected health information. It is understood and agreed that Provider is, and will be, a "business associate" of Company for purposes of HIPAA and a "service provider" of Company for purposes of GLBA because of the delegated functions it is performing on behalf of Company.

9.2 HIPAA and GLBA Definitions. For purposes of Sections 9.2 through 9.8 the following terms shall have the meaning set forth below:

a. C.F.R. "C.F.R." means the Code of Federal Regulations.

b. Designated Record Set. "Designated Record Set" has the meaning assigned to such term in 45 C.F.R. 164.501.

c. Member Information. "Member Information" means nonpublic personal financial and health information about a customer, whether in paper, electronic or other form. Member Information includes any such information provided by the customer as part of a request for information about, or an application for, a Company insurance product or service, even if no such insurance product or service is subsequently provided to the customer.

d. Electronic Protected Health Information. "Electronic Protected Health Information" means information that comes within paragraphs 1(i) or 1(ii) of the definition of "Protected Health Information", as defined in 45 C.F.R. 160.103.

e. Individual. "Individual" shall have the same meaning as the term "individual" in 45 C.F.R. 164.501 and shall include a person who qualifies as personal representative in accordance with 45 C.F.R. 164.502 (g).

f. Privacy and Security Rules. "Privacy and Security Rules" means the regulations promulgated by the Department of Health and Human Services at 45 C.F.R. Parts 160-164, Subparts A, C and E, which regulations implement the privacy and security requirements of the Administrative Simplification provisions of HIPAA.

g. Protected Health Information "Protected Health Information" shall have the same meaning as the term "Protected Health Information", as defined by 45 C.F.R. 160.103, limited to the information created or received by Provider from or on behalf of Company.

h. Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 C.F.R. 164.501.

i. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

j. Security Incident. "Security Incident" shall have the same meaning as the term "security incident" in 45 C.F.R. 164.304.

k. Service Provider. "Service Provider" means any person or entity that provides services to Company and maintains, processes or otherwise is permitted access to Company's Member Information.

l. Standard Transactions. "Standard Transactions" means the electronic health care transactions for which HIPAA standards have been established, as set forth in 45 C.F.R. Parts 160-162.

9.3 Obligations and Activities of Provider with Respect to HIPAA.

a. Provider agrees to not use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required by Law. Provider shall also comply with any further limitations on uses and disclosures agreed by Company in accordance with 45 C.F.R. 164.522 provided that such agreed upon limitations have been communicated to Provider according with Section 12.5.1.c of this Agreement.

b. Provider agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

c. Provider agrees to mitigate, to the extent practicable, any harmful effect that is known to Provider of a use or disclosure of Protected Health Information by Provider in violation of the requirements of this Agreement.

d. Provider agrees to report to Company any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.

e. Provider agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Provider on behalf of Company agrees to the same restrictions and conditions that apply through this Agreement to Provider with respect to such information. In no event shall Provider, without Company's prior written approval, provide Protected Health Information received from, or created or received by Provider on behalf of Company, to any employee or agent, including a subcontractor, if such employee, agent or subcontractor receives, processes or otherwise has access to the Protected Health Information outside of the United States.

f. Provider agrees to provide access, at the request of Company, and in the time and manner designated by Company, to Protected Health Information in a Designated Record Set, to Company or, as directed by Company, to an Individual in order to meet the requirements under 45 C.F.R. 164.524. Company's determination of what constitutes "Protected Health Information" or a "Designated Record Set" shall be final and conclusive. If Provider provides copies or summaries of Protected Health Information to an Individual it may impose a reasonable, cost-based fee in accordance with 45 C.F.R. 164.524(c)(4).

g. Provider agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Company directs or agrees to pursuant to 45 C.F.R. 164.526 at the request of Company or an Individual, and in the time and manner designated by Company. Provider shall not charge any fee for fulfilling requests for amendments. Company's determination of what Protected Health Information is subject to amendment pursuant to 45 C.F.R. 164.526 shall be final and conclusive.

h. Provider agrees to make (i) internal practices, books, and records, including policies and procedures relating to the use and disclosure of Protected Health Information received from, or created or received by Provider on behalf of, Company, and (ii) policies, procedures, and documentation relating to the safeguarding of Electronic Protected Health Information available to the Company, or at the request of the Company to the Secretary, in a time and manner designated by the Company or the Secretary, for purposes of the Secretary determining Company's compliance with the Privacy and Security Rules.

i. Provider agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Company to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. 164.528.

j. Provider agrees to provide to Company, in the time and manner designated by Company, the information collected in accordance with Section 9.3i of this Agreement, to permit Company to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. 164.528.

k. Provider acknowledges that it shall request from the Company and so disclose to its affiliates, subsidiaries, agents and subcontractors or other third parties, only the minimum Protected

Health Information necessary to perform or fulfill a specific function required or permitted hereunder.

l. With respect to Electronic Protected Health Information, Provider shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of Company, as required by 45 C.F.R. Part 164, Subpart C.

m. With respect to Electronic Protected Health Information, Provider shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information, agrees to implement reasonable and appropriate safeguards to protect it.

n. Provider shall report to Company any Security Incident of which it becomes aware.

o. If Provider conducts any Standard Transactions on behalf of Company, Provider shall comply with the applicable requirements of 45 C.F.R. Part 160-162.

9.4 Permitted Uses and Disclosures by Provider

9.4.1 General Use and Disclosure. Except as otherwise limited in this Agreement, Provider may use or disclose Protected Health Information to perform its obligations and Services to Company, provided that such use or disclosure would not violate the Privacy and Security Rules if done by Company or the minimum necessary policies and procedures of the Company.

9.4.2 Specific Use and Disclosure Provisions

a. Except as otherwise limited in this Agreement, Provider may use Protected Health Information for the proper management and administration of the Provider or to carry out the legal responsibilities of the Provider.

b. Except as otherwise limited in this Agreement, Provider may disclose Protected Health Information for the proper management and administration of the Provider, provided that disclosures are Required By Law, or Provider obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Provider of any instances of which it is aware in which the confidentiality of the information has been breached.

c. Except as otherwise limited in this Agreement, Provider may use Protected Health Information to provide Data Aggregation services to Company as permitted by 45 C.F.R. 164.504(e)(2)(i)(B).

d. Provider may use Protected Health Information to report violation of law to appropriate Federal and state authorities, consistent with 45 C.F.R. 164.502 (j)(1).

9.5 Obligations of Company With Respect to HIPAA.

9.5.1 Provisions for Company to Inform Provider of Privacy Practices and Restrictions

a. Company shall notify Provider of any limitation(s) in Company's notice of privacy practices

that Company produces in accordance with 45 C.F.R. 164.520, to the extent that such limitation(s) may affect Provider's use or disclosure of Protected Health Information.

b. Company shall provide Provider with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes affect Provider's use or disclosure of Protected Health Information.

c. Company shall notify Provider of any restriction to the use or disclosure of Protected Health Information that Company has agreed to in accordance with 45 C.F.R. 164.522, to the extent that such restriction may affect Provider's use or disclosure of Protected Health Information.

9.5.2 Permissible Requests by Company. Except as may be set further in Section 9.4.2, Company shall not request Provider to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy and Security Rules if done by Company.

9.6 Obligations of Provider With Respect to GLBA.

a. Provider agrees to implement a comprehensive written information security program that includes administrative, technical and physical safeguards for the protection of Member Information that are appropriate to Provider's size, complexity, nature and scope of activities, and that is designed to:

(i) ensure the integrity and confidentiality of Member Information;
(ii) protect against any anticipated threats or hazards to the security or integrity of Member Information; and
(iii) protect against unauthorized access to, or use of, Member Information that could result in substantial harm or inconvenience to any customer.

b. Provider agrees to ensure that any agent, including a subcontractor, to whom it provides Member Information received from, or created or received by Provider on behalf of Company, agrees to the same restrictions and conditions that apply through this Agreement to Provider with respect to such Member Information.

c. In no event shall Provider, without Company's prior written approval, provide Member Information (received from, or created or received by Provider on behalf of Company) to any employee or agent, including a subcontractor, if such employee, agent or subcontractor receives, processes, or otherwise has access to the Member Information outside of the United States.

d. Provider agrees to make policies, procedures, and documentation relating to the safeguarding of Member Information available to Company, or at the request of Company to the applicable state department of insurance, in a time and manner designated by the Company or department of insurance, for purposes of the department determining Company's compliance with GLBA.

e. Provider agrees to affirm in writing, upon request from Company from time to time, Provider's continued compliance with its obligations under this Agreement.

9.7 Term and Termination.

a. Term. Notwithstanding any provision to the contrary contained in this Agreement, the provisions of this Article 9 shall survive termination of this Agreement and shall only

terminate when all of the Protected Health Information and Member Information provided by Company to Provider, or created or received by Provider on behalf of Company, is destroyed or returned to Company, or, if it is infeasible to return or destroy Protected Health Information and Member Information, protections are extended to such information, in accordance with the provisions in this Section.

b. Effect of Termination.

i. Except as provided in paragraph b(ii) of this Section 9.7, upon termination of this Agreement, for any reason, Provider shall return or destroy all Protected Health Information and Member Information received from Company, or created, maintained, transmitted or received by Provider on behalf of Company. This provision shall apply to Protected Health Information and Member Information that is in the possession of subcontractors or agents of Provider. Provider shall retain no copies of the Protected Health Information or Member Information.

ii. In the event the Provider determines that returning or destroying the Protected Health Information or Member Information is infeasible, Provider shall provide to Company notification of the conditions that make return or destruction infeasible and the purposes of Provider's continued use. Upon mutual agreement of the parties that return or destruction of Protected Health Information or Member Information is infeasible and Provider has a legitimate purpose in continued use of the Protected Health Information or Member Information, Provider shall extend the protection of this Agreement to such Protected Health Information or Member Information and limit further uses and disclosures of such Protected Health Information or Member Information to those purposes that make the return or destruction infeasible, for so long as Provider maintains such Protected Health Information or Member Information.

9.8 Miscellaneous.

a. Regulatory References. A reference in this Agreement to a section in the Privacy and Security Rules means the section as in effect or as amended.

b. Amendment. Upon the enactment of any law or regulation affecting the use or disclosure of Protected Health Information, the safeguarding of Electronic Protected Health Information or the safeguarding of Member Information, or the publication of any decision of a court of the United States or any state relating to any such law or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, either party may, by written notice to the other party, amend the Agreement in such manner as such party determines necessary to comply with such law or regulation. If the other party disagrees with such amendment, it shall so notify the first party in writing within thirty (30) days of the notice. If the parties are unable to agree on an amendment within thirty (30) days thereafter, then either party may terminate this Agreement upon written notice to the other party, which effective date of termination shall be at least one hundred eighty (180) days following the receipt of such written notice of termination.

c. Interpretation. Any ambiguity in this Article 9 shall be resolved to permit Company to comply with the Privacy and Security Rules and GLBA. In the event of any inconsistency or conflict between this Article 9 and any other agreement between the parties, the terms, provisions and conditions of this Article 9 shall govern and control.

d. No third party beneficiary. Nothing express or implied in this Article 9 is intended to confer,

nor shall anything herein confer, upon any person other than the parties and the respective successors or assigns of the parties, any rights, remedies, obligations, or liabilities whatsoever.

10.0 MISCELLANEOUS

10.1 Amendments.

This Agreement constitutes the entire understanding of the Parties hereto and no changes, amendments or alterations shall be effective unless signed by both Parties, except as expressly provided herein. Notwithstanding the foregoing, at Company's discretion, Company may, upon at least thirty (30) days' advance written notice (unless a shorter period is required by applicable law, order or directive), amend this Agreement in order to comply with applicable law or regulation, or any order or directive of any governmental agency, including without limitation any requirements relating to the Plan or other Company Government Programs set forth in contracts or requests for proposals awarded to Company. In the event that Provider reasonably believes such amendment is likely to have a material adverse financial impact upon Provider, Provider agrees to notify Company, during that thirty (30) day notice period, specifying the specific bases demonstrating a likely material adverse financial impact. Thereafter, the Parties will attempt to negotiate in good faith an appropriate additional amendment to this Agreement. In the event the parties are unable to agree to any such amendment within thirty (30) days of Provider's notice, then either party may terminate this Agreement upon written notice to the other party, which effective date of termination shall be at least one hundred eighty (180) days following the receipt of such written notice of termination. During the aforementioned one hundred eighty (180) day period, the terms of this Agreement shall remain in their original form and not be amended unless any such regulatory agency and/or accreditation body expressly directs (either in direct response to an inquiry from either party to this Agreement or by any other means) the effectuation of such amendment during the remaining one hundred eighty (180) days of the Agreement.

10.2 Waiver.

The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, all waivers must be in writing and signed by an authorized officer of the Party to be charged. Provider waives any claims or cause of action for fraud in the inducement or execution related hereto.

10.3 Governing Law.

This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State where Provider is located.

10.4 Liability.

Either Party's liability, if any, for damages to the other Party for any cause whatsoever arising out of or related to this Agreement, and regardless of the form of the action, shall be limited to the damaged Party's actual damages. Neither Party shall be liable for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whatsoever sustained as a result of a breach of this Agreement or any action, inaction, alleged tortious conduct, or delay by the other Party.

10.5 Severability.

Any determination that any provision of this Agreement or any application thereof is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of

any other provision of this Agreement. Neither Party shall assert or claim that this Agreement or any provision hereof is void or voidable if such Party performs under this Agreement without prompt and timely written objection.

10.6 Successors; Assignment.
This Agreement relates solely to the provision of Covered Services by Provider and its contracted staff and Subcontracted Providers and does not apply to any other organization which succeeds to Provider assets, by merger, acquisition or otherwise. Neither Party may assign its rights or delegate its duties and obligations under this Agreement, except as specifically provided herein, without the prior written consent of the other Party, which consent may not be unreasonably withheld; provided, however, that either party may assign its rights or delegate its duties and obligations to an Affiliate so long as any such assignment or delegation will not have a material impact upon the rights, duties and obligations of the other party.

10.7 Headings.
The headings contained in this Agreement are included for purposes of convenience only, and shall not affect in any way the meaning or interpretation of any of the terms or provisions of this Agreement.

10.8 Notices.
Unless otherwise specified herein, any notice required to be given pursuant to the terms and provisions hereof shall be effective only if given in writing and sent by overnight delivery service with proof of receipt, or by certified mail return receipt requested. Notices shall be sent to the following addresses (which may be changed by giving notice in conformity with this Section 10.8). Each Party shall notify the other Party of any changes in their respective information provided below.

To Provider at:

[Placeholder]

and to Company at:

[Placeholder]

10.9 Remedies.
Notwithstanding Sections 8.3 and 10.4, the Parties agree that each has the right to seek any and all remedies at law or equity in the event of breach or threatened breach of Section(s) 5.5, 6.6 and 7.3.

10.10 Non-Exclusivity.
This Agreement is not exclusive, and nothing herein shall preclude either Party from contracting with any other person or entity for any purpose. Company makes no representation or guarantee as to the number of Members who may select or be assigned to Provider.

10.11 Force Majeure.
If either Party shall be delayed or interrupted in the performance or completion of its obligations hereunder by any act, neglect or default of the other Party, or by an embargo, war, act of terror, riot, incendiary, fire, flood, earthquake, epidemic or other calamity, act of God or of the public enemy, governmental act (including, but not restricted to, any government priority, preference, requisition, allocation, interference, restraint or seizure, or the necessity of complying with any governmental

order, directive, ruling or request) then the time of completion specified herein shall be extended for a period equivalent to the time lost as a result thereof. This Section 10.11 shall not apply to either Party's obligations to pay any amounts owing to the other Party, nor to any strike or labor dispute involving such Party or the other Party.

10.12 Survival.

In addition to those provisions which by their terms survive expiration or termination of this Agreement, Sections 5.5, 6.5, 7.3 and this Article 10 shall survive expiration or termination of this Agreement, regardless of the cause giving rise thereto.

10.13 Entire Agreement.

This Agreement (including any attached exhibits and schedules) constitutes the complete and sole contract between the Parties regarding the subject hereof and supersedes any and all prior or contemporaneous oral or written representations, communications, proposals or agreements not expressly included herein and may not be contradicted or varied by evidence of prior, contemporaneous or subsequent oral representations, communications, proposals, agreements, prior course of dealings or discussions of the Parties. There are no oral agreements between the Parties. Provider represents that it has not relied on any data, financial analysis, reports, notes, proposals, conclusions or projections, whether made orally or in writing, made by Company or any of its representatives, agents, employees or advisors, in connection with negotiation, acceptance, execution or delivery of the Agreement by Provider.

10.14 Counterparts.

This Agreement may be executed in separate counterparts, each of which shall be deemed an original, but both of which together shall constitute one and the same instrument. This Agreement shall become binding when one or both counterparts hereof, individually or taken together, shall bear the signatures of the Parties.

10.15 Incorporation of Recitals.

The Parties incorporate the recitals into this Agreement as representations of fact to each other.

IN WITNESS WHEREOF, the undersigned parties have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.

PROVIDER	**COMPANY**
By:	_____
_	By:_____
Printed Name: _____	Printed Name: _____
Title: _____	Title: _____
Date: _____	Date:_____

PROGRAM PARTICIPATION SCHEDULE

Provider agrees to participate in the Plans and other health benefit programs listed herein:

Those Medicaid Plans and programs offered by Company within the State of _____ [Identify the State].

SERVICES AND COMPENSATION SCHEDULE

[Placeholder]

EXHIBIT A – Subcontractor Regulatory Compliance Addendum

[Placeholder]

Delegated Function - Call Center Agreement

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DELEGATED FUNCTION - CALL CENTER

A. Description of Call Center Services. Delegated Entity will provide services for Call Center service provided as more fully described below.

1. Procedures
   Delegated Entity agrees to establish procedures to ensure consistent and accurate management of Call Center services. A Call Center quality control program shall be maintained by Delegated Entity at all times during the term of the Agreement.

2. Education
   Delegated Entity agrees to provide education to Call Center staff regarding proper call procedures.

3. Toll Free Number
   Delegated Entity shall establish and maintain customer call centers where Company members can call a toll-free number with customer service questions, appeals, grievances, coverage determinations and complaints between the hours of 8:00 am and 5:00 pm Monday through Friday, for all time zones.

4. Ability to Observe Service
   Delegated Entity will provide the capability to record and monitor live calls to ensure compliance with this Agreement and Company's call handling procedures, and to identify training opportunities.

5. Reporting
   Delegated Entity will submit to Company, by the first of the month, monthly report outlining the following:
   - Delegated Entity's performance against the Performance Obligations set forth in Section B below
   - Monthly Call Quality reports

6. Data Security
   Delegated Entity will have procedures in place to ensure security of member data. All materials including but not limited to, training material, and equipment must be secured in a locked environment. Security violation incident reporting must be provided to Aetna on a monthly basis.

7. Facilities
   Delegated Entity will provide all environmental support required for maintaining all computer hardware at each Individual Site, including space, power, cooling, emergency power supply and uninterruptible power supply. Delegated Entity will provide immediate response to problems and continuous support through resolution.

8. Disaster Recovery Plan
   Delegated Entity shall provide to Company a Disaster Recovery Plan, (DRP) subject to Company review and approval.

9. Appeals
Delegated Entity agrees to cooperate with and participate in Company's applicable appeal, grievance and external review procedures (including, but not limited to, Medicare appeals and expedited appeals procedures), provide Company with the information necessary to resolve same, and abide by decisions of the applicable appeals, grievance and review committees.

B. Performance Standards.

1. Operating Hours. Operating hours will initially be from 8:00 am to 5:00 pm Monday through Friday, for all time zones in the continental United States. For all Customer calls received after normal operating hours the Delegated Entity will provide an after-hours message stating the normal business hours. The call center will be closed on the following Federal Holidays: Thanksgiving, Christmas Day, New Year's Day, Memorial Day, 4th of July, and Labor Day.

2 Performance Obligations. Delegated Entity represents and warrants to Company, and Delegated Entity covenants to Company that at all times hereunder, its provision of Customer Service services are and shall continue to be in accordance with the following:

a. Average Speed of Answer for telephone calls placed by members and/or providers is 30 seconds or less. Average Speed of answer of telephone calls placed by Members and Providers is measured from the time the caller chooses an option that results in the caller being placed in queue for response by a customer service representative to the time a representative responds to the call. The result expresses the sum of all waiting times for all calls answered by the queue divided by the number of incoming calls answered.

b. Telephone Abandon Rate is 5 percent or less; The percentage of inbound phone calls made to a call center that are abandoned by the customer before speaking to a customer service representative. It is calculated as abandoned calls divided by total inbound calls (in percent).

c. Telephone Service Factor of seventy-five (75%) of all calls answered in 30 seconds or less. The percentage of calls answered within a specified amount of time. The service level is set at 30 seconds and 75% of the calls are to be answered within 30 seconds

d. A quality program should include elements of internal random call monitoring with scoring criteria with a standard of 96.25 percent.

Delegated Function - Claims Management Agreement

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DELEGATED FUNCTION – CLAIMS MANAGEMENT

A. Description of Claims Management Services. Delegated Entity will provide services for Claims Management services provided as more fully described below.

1. Procedures
Delegated Entity agrees to establish procedures to ensure consistent and accurate management of claims. A Claims Management quality control Program shall be maintained by Delegated Entity at all times during the term of this Agreement.

2. Education
Delegated Entity agrees to provide education to Participating Providers regarding the following:
   a. Proper billing forms and procedures
   b. Copayment collection
   c. Balance billing issues

3. Systems
Delegated Entity agrees to establish and maintain systems to provide, and Delegated Entity will provide Company with, the following:

   a. Claims payment workflow:
      1. Acknowledgment by Participating Providers that negotiated rates are payment in full
      2. Payment and remittance advice and information
      3. Processing standards for Clean Claim adjudication
      4. Management of pending claims
      5. Management of payments to non-Participating Providers
      6. Reimbursement of Members for eligible expenses
      7. Standards to ensure accuracy and timeliness of payment consistent with Company policies and
      8. Applicable federal and state law and regulation
      9. Procedures to determine if a claim was incurred as a result of an authorized referral

   b. Claim denial workflow:
      1. Notification of Company of recommended claim denials and reasons for denial
      2. Assistance to Company to manage Member appeals and grievance relating to denial of claims for Covered Services, including expedited appeals
      3. Denial matrix

   c. Reporting in Company-required formats:
      1. Denial, pend and in-process reports
      2. In house claims inventory
      3. Timelines and accuracy reports
      4. Interest paid reports
      5. Problem reports
      6. Annual certification by executive officer of Delegated Entity certifying compliance with applicable law and the material terms of this Agreement for the immediately preceding contract year

4. Claims Processors
Delegated Entity agrees to ensure that the claims processors whom Delegated Entity has retained to perform the Claims Management services under this Agreement have an average of three (3) years processing experience.

5. Member Inquiries
Delegated Entity agrees to immediately forward to Company all Member inquiries regarding Claims Management. In every event such inquiries will be forwarded in sufficient time to allow Company to satisfy its obligations under applicable federal and state law and regulation regarding such inquiries.

6. Fraud/Fraud Recovery
Delegated Entity agrees to maintain internal controls to detect and deter provider and internal personnel fraud. Delegated Entity agrees to also maintain a fraud recovery program in accordance with standards set by Company to include use of training materials as provided by Company.

7. Coordination of Benefits
Delegated Entity agrees to pursue coordination of benefits and subrogation in accordance with Company standards, policies and procedures.

8. Appeals
Delegated Entity agrees to cooperate with and participate in Company's applicable appeal, grievance and external review procedures (including, but not limited to, Medicare appeals and expedited appeals procedures), provide Company with the information necessary to resolve same, and abide by decisions of the applicable appeals, grievance and review committees.

B. Performance Standards.

1. Performance Obligations. Delegated Entity represents and warrants to Company, and Delegated Entity covenants to Company that at all times under this Agreement, its provision of Claims Management services are and shall continue to be in accordance with the following:

   a. Ninety-nine percent (99%) financial accuracy including any requirements of customer specific Plans;

   b. Ninety-eight percent (98%) statistical accuracy including any requirements of customer specific Plans;

   c. For Members of commercial managed care Plans, one hundred percent (100%) of all Clean Claims must be processed and paid within forty-five (45) days (or such shorter time as required by applicable law or regulation) of actual receipt by Delegated Entity of a Clean Claim;

   d. For Members of commercial managed care Plans, one hundred percent (100%) of all non-Clean Claims must be processed and denied, advised on or paid, as the case may be, within forty-five (45) days (or such shorter time as required by applicable law or regulation) of receipt by Delegated Entity;

   e. For, where applicable, Members of Medicare Plans:

      i. Ninety-five (95%) of all Clean Claims submitted by providers not contracted with Delegated Entity or Company ("Non-Contracted Providers") must be processed and paid within the earlier of: (1) thirty (30) calendar days of receipt by Delegated Entity of a Clean Claim, or (2) thirty (30) calendar days of receipt by Company of a Clean Claim, or (3) such shorter time as required by applicable federal laws, rules or regulations;

      ii. Delegated Entity must pay interest on all Clean Claims submitted by Non-Contracted Providers that are not paid within thirty (30) calendar days of receipt by Delegated Entity in accordance with federal laws, rules and regulations;

      iii. Ninety-five (95%) of all Clean Claims and non-Clean Claims submitted by Contracted

Providers must be processed and paid or denied within the timeframes and according to the terms specified in the contracts between such providers and Delegated Entity;

iv. Ninety-five (95%) of all Medicare claims submitted by Non-Contracted Providers that are not Clean Claims ("Non-Clean Claim") must be: (1) properly developed within sixty (60) calendar days from the date of the request for payment (or such shorter time as required by applicable federal laws, rules or regulations) to obtain any information needed to determine whether the Non-Clean Claim should be paid or denied; and (2) either denied or paid within sixty (60) calendar days from the date of the request for payment (or such shorter time as required by applicable federal laws, rules or regulations); and

v. Delegated Entity must use denial letters approved by Company and CMS for denied Medicare claims.

vi. Written member notification of Specialist Terminations for Continuity and Coordination of Care

vii. Written member notification of Specialist Termination Reinstatements

f. In the event Delegated Entity receives an unpaid claim or portion of such claims for which Company has financial responsibility, whether or not Delegated Entity can determine that Company has such financial responsibility, Delegated Entity agrees to send claim to Company within five (5) days of receipt.

2. Disclosure of Fee Schedules. Upon contracting, annually thereafter on or before the contract anniversary date, and in addition upon the contracted Provider's written request, the Delegated Entity must disclose to contracting providers or provider groups the following information:

a. The complete fee schedule for the contracting provider or provider group consistent with the contracting provider's direct written agreement with the Delegated Entity.

b. Each fee schedule shall state the dollar amount allowable for each CPT code for covered services rendered by the contracted provider's office.

c. Upon written request from a contracted provider or provider group, the Delegated Entity will provide the fee schedule for up to fifty (50) CPT codes as specified by the contracted provider or provider group. Delegated Entity will be obligated to honor only on such request made annually by the contracted provider or provider group.

3. Performance Guarantees. Delegated Entity acknowledges that Company has agreements with its customers which contain performance guarantees for claims payment. If Company is subject to assessments of any kind including, but not limited to, penalties and interest, by any customer(s) as result of Delegated Entity's failure to meet any performance guarantee(s), Delegated Entity agrees to pay to Company the amount of any assessment incurred by Company for such failure. Company will communicate to Delegated Entity any standards that are materially different than those otherwise specified in this document. Company shall notify Delegated Entity of any such penalty, interest or assessment.

4. Financial Protections. Delegated Entity agrees to keep in force a letter of credit or performance bond from a financial institution approved by Company in a form acceptable to Company. The amount of the letter of credit or performance bond shall be at least $_____. The initial Letter of Credit for $_____ represents six (6) months of per member per month (pmpm) agreed upon allocations (the "Base Amount"). Company is hereby authorized by Delegated Entity to draw upon the Letters of Credit under the circumstances described in this Section 4. Delegated Entity and Company shall execute all documents necessary to enable Company to perform such functions. Any

requirements for additional letter of credit or bond amounts must be met within thirty (30) days of written notification by Company to Delegated Entity.

Company may draw upon the letter of credit or performance bond to pay claims upon any of the following events: (1) Delegated Entity fails to meet the claims payment obligations set forth in Section B of this Attachment; (2) there has been a filing in bankruptcy court, the appointment of received, the marshalling of debts or assets, or the proposed settlement of outstanding debts under applicable reorganization or insolvency laws filed by or against Delegated Entity; or (3) Delegated Entity has ceased to conduct business.

Upon termination of this Agreement Delegated Entity shall maintain the letter of credit or performance bond until all monies related to this Agreement have been exchanged by the parties, but in no event for a period of less than twelve (12) months after such termination. Company is hereby authorized by Delegated Entity to draw upon the letter of credit or performance bond under the circumstances described in this provision. All bank charges in connection with the letter of credit or performance bond are for the account of the Delegated Entity. Delegated Entity and Company shall execute all documents necessary to enable Company to perform such functions.

Delegated Function – Credentialing Agreement

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DELEGATED FUNCTION - CREDENTIALING

A. Description of Credentialing Services. Delegated Entity will provide services for Credentialing services provided as more fully described below.

1. Written Policies and Procedures
   Delegated Entity will establish and maintain written policies and procedures for the Credentialing and biennial or triennial (as required by applicable state law and/or accreditation standards) Recredentialing of Providers who [*apply to become Participating Providers*.] OR [*apply for medical staff membership or clinical privileges*.] The policies and procedures will also set forth the scope of the Credentialing and Recredentialing Program (i.e. what categories of Providers are credentialed). These policies and procedures and any substantive revisions thereto shall be mutually agreed upon by the parties, which mutual agreement shall not be unreasonably withheld or delayed.

2. Credentialing Committee
   Delegated Entity agrees to establish or maintain a credentialing committee to make recommendations regarding Credentialing and Recredentialing decisions. This committee shall include an appropriate number of Providers who are physicians, as required by NCQA and any applicable state law or regulation.

3. Credentialing and Recredentialing Standards
   Delegated Entity agrees to adopt Credentialing and Recredentialing criteria that include at a minimum primary verification, from approved sources, (including but not limited to verification in writing, via telephone, microfiche, or on-line query) of the following:

   a. Current valid license to practice in each state where Provider will provide services to Members.

   b. Clinical privileges in good standing at [*a hospital under contract with Company to provide services to Members* OR [*Hospital*] (for Providers who customarily maintain clinical privileges at a hospital).

   c. Valid DEA or state narcotics certification, as applicable.

   d. Graduation from:
      i. an accredited medical school and completion of an accredited residency or board certification, as applicable, for physicians, or
      ii. a nationally accredited program and/or completion of appropriate clinical training or education for non-physicians.

   e. Work history.

   f. Current, adequate malpractice insurance in accordance with Company's policy.

   g. Professional liability claims history.

   h. Data supplied to the Company shall include the initial date of the credentialing decision of the Delegated Entity; if different, the initial date of provider participation at the Delegated Entity; and, the last date of recredentialing at the Delegated Entity.

i. Delegated Entity's primary verification standards shall be consistent with NCQA standards and any other applicable Company standards and regulatory requirements.
j. Sanctions information (licensure, Medicare, and Medicaid)
k. Medicare Opt-out (CMS)
l. Performance data during the recredentialing process (CMS)

4. Application Process
Delegated Entity agrees to establish or maintain a formal application process which requires that each Provider complete either Company's application to become a Participating Provider; when approved by Company, the Delegated Entity's own application; or, where applicable, a state-mandated application.

Delegated Entity agrees to include an attestation by the applicant to the accuracy and completeness of the information on the credentialing and recredentialing applications. If Delegated Entity uses its own application, the release/authorization form must be approved by Company.

Delegated Entity agrees to report to Company within five (5) calendar days any "adverse action" taken by, or notice of such action received by, Delegated Entity with respect to the licensure, medical staff privileges or membership status of any Participating Provider. For purposes of this section, "adverse action" means an action that denies, restricts, encumbers, revokes, suspends, probates, or constitutes a censure or reprimand (whether public or private), the voluntary surrender of licensure or privileges to avoid such actions, voluntary payment of fines or consent to other disciplinary actions, and the initiation of any investigation that could result in such action.

5. Querying Process
The Credentialing and Recredentialing process shall include obtaining information on the Provider from the National Practitioner Data Bank and the Federation of State Medical Boards of the United States, Inc. or equivalent body, as applicable; information to ascertain whether Provider has been the subject of investigation or sanction activity by any government health program including but not limited to Medicare, Medicaid or CHAMPUS; and information concerning any disciplinary action by any licensing agency.

6. Recredentialing
In addition to the requirements stated above, Delegated Entity agrees to conduct ongoing **recredentialing** which includes the standards in Sections 3 through 5 of this Attachment 1.

7. Sanctions, Terminations, and Suspensions
Delegated Entity agrees to adopt policies and procedures, which, at a minimum, comply with the requirements of the Health Care Quality Improvement Act of 1986, DHHS Office of Inspector General, Office of Personnel Management, NCQA, CMS, standards, and any applicable state peer review law and are acceptable to Company, to reduce, suspend, or terminate the Participating Provider status of a Provider. Company retains the right to approve, suspend or terminate providers. Such policies and procedures shall include a mechanism for reporting to appropriate authorities, including but not limited to the National Practitioner Data Bank and applicable state regulatory agency, serious quality deficiencies leading to suspension or termination and an appeal process for adversely affected Participating Providers. Delegated Entity agrees to notify Company within five (5) calendar days of any report submitted pursuant to this section.

8. Termination Data
   Upon termination of this agreement Delegated Entity agrees to provide historical data, or access to such data, regarding the services it has performed in this agreement.

9. Site Visits
   Company shall set the standards and thresholds for office-site criteria and medical/ treatment record-keeping practices for all practitioners within its network for physical accessibility, physical appearance, adequacy of waiting and examining room space, availability of appointments and adequacy of treatment record keeping.

   Company shall have a process to monitor and investigate member complaints related to the quality of all practitioner office sites that were identified as having member complaints related to the site's accessibility, appearance, and adequacy of waiting/exam room space. In addition the following steps must be taken:

   a. Company sets reasonable thresholds for the number of complaints for physical accessibility, physical appearance, and adequacy of waiting and examining Room Space that must be received before conducting an office site visit, which meet Company standards.

   b. The Delegated Entity must conduct the site visit within 30 days of the reasonable complaint threshold and must institute actions for improvement with sites that do not meet the thresholds.

   c. The Delegated Entity must evaluate the effectiveness of the actions at least every six months and for every subsequent complaint until sites with deficiencies meet the thresholds. Delegated Entity will evaluate and report back to the plan.

   d. The Delegated Entity or the site must develop and implement a corrective action plan for improvement if the site does not meet the required performance thresholds.

   e. The Delegated Entity must use a standardized site visit survey form that incorporates office site criteria to assess each office about which it has received a member complaint. This survey must meet Company standards.

   f. The Delegated Entity must complete the survey form at the time of or shortly after each site visit.

   g. The Delegated Entity must provide documentation that office documentation practices are discussed with practitioners or staff including:

      i. the forms and methods used to keep consistent information
      ii. how the practice ensures confidentiality of records

   h. The Delegated Entity must assess medical/treatment records for orderliness and documentation practices

[Where it has been determined that Site Visits will <u>not</u> be delegated, remove Section 9 of Attachment 1 and replace with the following:

9. <u>Site Visits</u>
   Company shall set the standards and thresholds for office-site criteria and medical/ treatment record-keeping practices for all practitioners within its network for physical accessibility, physical appearance, adequacy of waiting and examining room space, availability of appointments and adequacy of treatment record keeping.

   Company shall have a process to monitor and investigate member complaints related to the quality of all practitioner office sites that were identified as having member complaints related to the site's accessibility, appearance, and adequacy of waiting/exam room space. In addition the following steps must be taken:

   a. Company sets reasonable thresholds for the number of complaints for physical accessibility, physical appearance, and adequacy of waiting and examining Room Space that must be received before conducting an office site visit, which meet Company standards.

   b. Company must conduct the site visit within 60 days of the reasonable complaint threshold and must institute actions for improvement with sites that do not meet the thresholds. The Company will address any deficiencies, via a corrective action plan, with the office to implement such corrective actions.

   c. The Company must evaluate the effectiveness of the actions at least every six months and for every subsequent complaint until sites with deficiencies meet the thresholds.**]**

10. Delegated Entity agrees to monitor state board sanction lists, DHHS Office of Inspector General Sanction Lists and the Office of Personnel Management Debarment Lists within 30 days of their publication. Where state board sanction lists are not published regularly, state board sanction review is required, at a minimum, every 6 months. Notification shall be made to Company when a practitioner is found on the sanction or debarment lists.

11. Delegated Entity agrees to perform ongoing review complaints for all practitioner types.

12. Appeals. Delegated Entity agrees to establish and adopt applicable practitioner appeal policies and procedures (including, but not limited to, NCQA, CMS, and State appeal procedures), provide Company with the information necessary to resolve same, and abide by decisions of the applicable appeals committees.

Note: Company does not prohibit the Delegated Entity from collecting clinical and member experience data.

B. <u>Performance Standards</u>.

1. Unless otherwise agreed to by Company, such review shall be of the lesser of 50 files, or as may be necessary to satisfy Company obligations under the terms of this Agreement;

2. If required, Delegated Entity agrees to provide credentialing and recredentialing files to the Company during a NCQA accreditation survey of Company or a plan survey by another accrediting organization. Such access shall be maintained for the longer of six (6) years after the term of this Agreement or the period required by applicable law;

3. These reports shall be provided quarterly and at such other times as Company shall request or as Delegated Entity shall deem necessary or appropriate to ensure that Company is fully apprised of Delegated Entity's activities. The contents of these reports shall be mutually agreed upon by the parties, but shall, at a minimum, include the following information:

   i. Names and number of Providers approved, terminated, suspended, or denied under the Delegated Entity's Credentialing and Recredentialing Program.
   ii. Statistical Information which is mutually agreed upon by the parties.
   iii. The results of any studies or quality improvement projects related to Delegated Entity's Credentialing or Recredentialing program which were conducted or implemented.

4. Delegated Entity agrees that Entity is performing Credentialing and Recredentialing services under this Agreement on behalf of Company in accordance with the terms herein, and that information gathered or developed by Entity that is confidential or proprietary to Company, or is related to Credentialing or Recredentialing of Providers and Participating Providers is the exclusive property of Company; and;

5. Access to Data. If Company wishes to perform a site visit or review Credentialing or Recredentialing data on specific Participating Providers, Delegated Entity agrees to notify such specific Participating Providers that Company will be allowed access to Participating Provider's Credentialing and Recredentialing files, when requested. Delegated Entity further agrees that it will obtain prior written approval or release from such specific Participating Providers, as needed, for the purposes of this Agreement and to permit Company to review these files.

DELEGATED FUNCTION – CREDENTIALING (Organizational Providers)

A. Description of Credentialing Services. Delegated Entity will provide credentialing services, compliant with applicable NCQA, CMS, State requirements, as described below.

1. Written Policies and Procedures
   Delegated Entity will establish and maintain written policies and procedures for the Credentialing and Recredentialing of Organizational Providers, every three years. The policies and procedures will also set forth the scope of the Credentialing and Recredentialing Program (i.e. what types of Providers are credentialed). These policies and procedures and any substantive revisions thereto will be subject to the review by and approval of Company.

2. Credentialing Committee
   Delegated Entity agrees to establish or maintain a credentialing committee to make recommendations regarding Credentialing and Recredentialing decisions (as applicable).

3. Credentialing and Recredentialing Standards
   Delegated Entity agrees to adopt Credentialing and Recredentialing criteria that include the following:

   a. The Delegated Entity confirms that the Organizational Provider is in good standing with federal and state regulatory bodies by verifying the provider has an active

license and verifying that the Organizational Provider is not Medicare sanctioned or debarred.

b. The Delegated Entity confirms that the Provider has been reviewed and approved by an accrediting body.

c. If the Organizational Provider has not been approved by an accrediting body, the Delegated Entity conducts an on site review or obtains the most recent CMS or a state audit report and reviews it for compliance.

d. The Delegated Entity confirms the Organizational Provider has current and adequate malpractice insurance.

e. The Delegated Entity confirms the Organizational Provider has a policy related to advanced directives.

Delegated Function - Patient Management Agreement

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DELEGATED FUNCTION - PATIENT MANAGEMENT

A. Description of Patient Management Services. Delegated Entity will provide services for Patient Management services provided as more fully described below.

1. Patient Management Program
Delegated Entity agrees to maintain a written Patient Management plan description which includes policies and procedures to evaluate criteria, information sources and processes used to review and approve the provision of services to Members. These policies and procedures must be consistent with Company policies and procedures and must comply with the accreditation standards of NCQA (when applicable), as well as statutory and regulatory requirements and contractual obligations. Delegated Entity's Patient Management plan description should be revised as needed and submitted in writing to Company for review and approval at least annually, and more often if required by Company to keep Company apprised on Delegated Entity's obligations under this Agreement.

2. Patient Management Committee
Delegated Entity agrees to establish a Patient Management committee which agrees to be responsible for overseeing Patient Management activities. Delegated Entity's Patient Management committee membership should include at least three (3) members who are physicians, one of whom agrees to be a senior medical director of Delegated Entity, and who are representative of the primary and/or specialty care being reviewed. The Patient Management committee agrees to meet on a regular basis. A Patient Management representative from Company shall be entitled to attend any Patient Management committee meeting. Minutes of the committee meetings shall be maintained in a secure manner by Delegated Entity and made available to Company for review.

3. Patient Management Recommendations/Decisions
Delegated Entity agrees to comply with Company's benefit coverage guidelines. Delegated Entity agrees to utilize qualified medical professionals to make benefit coverage decisions and to supervise review decisions. Patient Management review decisions must be made in a timely manner and in accordance with timeframes mutually agreed upon between Company and Delegated Entity. Timeframes shall accommodate clinical urgencies. Delegated Entity agrees to monitor its compliance with such timeframes, and shall take all actions as are necessary to ensure compliance with such timeframes. All Patient Management review decisions by Delegated Entity shall reflect professional judgment exercised with that degree of care and skill customarily exercised by providers of health care services and in accordance with generally accepted medical standards. Patient Management recommendations by Delegated Entity shall be based upon the review of the entire record available and such additional information that Delegated Entity determines to be necessary and appropriate to conduct Patient Management services. A physician shall conduct a review of any denial recommendation based on medical necessity and shall use board-certified consultants when necessary to conduct the review of such denials. Delegated Entity agrees to ensure that the reason for any denial is clearly documented, including references to the specific Plan provision on which the determination is based, and is part of the notification sent to the Member and attending physician. Notification of a denial shall include appeal process information. Delegated Entity's physician reviewer shall make the initial denial/determination and Company retains the responsibility for the final decision on the denial determination and the appeal process.

4. Written Patient Management Review Decision Guidelines
Delegated Entity agrees to maintain a set of Patient Management review decision protocols that are based on reasonable medical evidence and consistent with Company's standards and guidelines. Delegated Entity agrees to review and update the criteria as needed, but no less than annually, and to provide Company with a written copy of any revision within ten (10) calendar days. Delegated Entity agrees to maintain and monitor consistent application of the criteria through monitoring review mechanisms of physicians and other reviewers. Delegated Entity agrees to inform Providers of Patient Management decision guidelines and to provide criteria to Providers upon request.

5. Medical Technology
Delegated Entity agrees to have written policies and procedures in place to distribute and implement Company's guidelines/protocols pertaining to the appropriate use of new medical technologies or new application of established technologies, including medical procedures, drugs and devices. Company retains the final authority over all decisions relating to coverage policy relating to new medical technologies and new applications of established technologies.

B. Performance Functions and Standards.

1. Performance Functions
Delegated Entity agrees to perform various Patient Management functions identified by Company, which may be subject to change. Any such change in Patient Management functions shall not be considered an amendment to this Agreement. Initially, Patient Management functions shall include those designated below, subject to the limitations specified:

	Medical	
Delegated Functions	**YES**	**NO**
a. Patient Management Notification of Emergency Services or any other Covered Services for which Delegated Entity is not delegated for Precertification		
b. Authorization of referrals in accordance with Delegated Entity's Patient Management Plan as approved by Company, including precertification of referrals to specialists;		
c. Precertification, and urgent concurrent review, of hospital admissions for non-Emergency Services and elective outpatient surgery and procedures (inclusive of, but not limited to, lab, x-ray, physical therapy, occupational therapy and speech therapy);		
d. Precertification, and urgent concurrent review, of items or services to be provided by a skilled nursing facility or other sub-acute facility, durable medical equipment company, home		

health agency, hospice, or diagnostic testing facility, in accordance with a Member's benefit plan;		
e. Concurrent Review and Discharge Planning;		
f. Case Management services for catastrophic disease and injury, subject to Section 8, below;		
g. Disease Management, subject to Section 8, below;		
h. Service denials, if appropriate, for those same service categories for which Delegated Entity is delegated to perform Precertification;		
i. Retrospective Review for those same service categories for which Delegated Entity is delegated to perform Precertification;		
j. Precertification of self-administered injectable medications (non-office administered) – Delegated Entity must utilize the Aetna Specialty Pharmacy Network if contractual financial responsibility is with Aetna		
k. Precertification of basic infertility benefits included in a Member's plan;		
l. Precertification of services included in Comprehensive and Advanced Reproductive Technology Infertility services subject to a Member's eligibility;		
m. Precertification of Bariatric services subject to a Member's eligibility;		
n. OOA for capitated services not available within Delegated Entity's network – includes Primary, Specialty and OOA referred by IPA, including medically necessary cosmetic surgery		
o. Written member notification of Specialist Terminations for Continuity and Coordination of Care		
p. Managing triage and referral of behavioral healthcare (Medicare HMO only)		

Note: Company does not prohibit the Delegated Entity from collecting clinical and member experience data.

2. Non-delegated Functions
Notwithstanding the above, unless otherwise communicated in writing by Company, Delegated Entity shall not be delegated any of the following functions: (a) authorization of experimental or investigational treatments or devices; (b) Member appeals or grievance handling; (c) authorization of organ or bone marrow transplant evaluation or procedures; (d) exceptions to Company's formulary or specified drug authorizations; (e) out-of-area care (Delegated Entity shall notify Company of Members who are requesting service out-of-area and Company shall manage all out-of-area services except as in line item "n" above); and (f) Medicare and commercial (HMO) Behavioral Health Outpatient/Inpatient utilization management services.

3. Services by Participating Providers
Delegated Entity agrees that, except in an emergency, all services shall be provided through Participating Providers.

4. Transition of Care
Transition of care for Members transitioning to Company from another health plan or for a Member receiving services from a non-participating provider shall be managed jointly by Company and Delegated Entity. Company has established guidelines to provide continuity of care and retains responsibility for the final decision on all transition of care cases.

5. Reporting Requirements
Company agrees to monitor and evaluate Patient Management reports from Delegated Entity on a regular basis. Delegated Entity agrees to provide Company with Patient Management information, including, but not limited to:

a. Patient Management plan (i.e. Utilization Management Program Description) and any updates or revisions, as applicable, to include signature page;

b. Annual written evaluation of Patient Management program (i.e. Utilization Management Program Evaluation);

c. Patient Management committee minutes describing Patient Management activity;

d. Annual Reporting:
   1) Patient Management plan (i.e. Utilization Management Program Description) and any updates or revisions, to include signature page;
   2) Written evaluation of Patient Management program (i.e. Utilization Management Program Evaluation); and
   3) Patient Management work plan (i.e. Utilization Management Work Plan).

e. Semi-Annual Reporting, at a minimum:
   1) Bed days/1000 - Commercial and Medicare, to include behavioral health data. if applicable;
   2) Admits/1000 - Commercial and Medicare, to include behavioral health data. if applicable;
   3) Average length of stay - Commercial and Medicare, to include behavioral health data. if applicable;

4) Number of Patient Management cases handled by type (precertification, concurrent or retrospective review), to include behavioral health data. if applicable;
5) Number of Patient Management cases handled by service (inpatient or outpatient), to include behavioral health data, if applicable ;
6) Number of denials and % rate, including Emergency Services ("ER") denials and behavioral health, if applicable;
7) Average turn-around-time for precertification requests (urgent and non-urgent); and
8) Summary report containing data mutually agreed upon by the parties, which shall at a minimum include data as outlined in items 1) through 7) above and may include additional utilization measures (including, but not limited to, Health Employer Data Information System ("HEDIS") utilization management measures).

f. Quarterly – Medicare Part C Organizational Determination reports

g. Monthly Reporting Requirements (should be submitted by the 20th day of each month):

TYPES OF REPORTS	COMMERCIAL	MEDICARE	
Medicare Expedited Organizational Determinations	N/A		
Medicare Termination of Services for Skilled Nursing Facility (SNF), Comprehensive Outpatient Rehabilitative Facility (CORF) and Home Health Agency (HHA) Discharges Log. Log should include the following: 1. Member Name; 2. Member ID #; 3. Type of Services to be Terminated; 4. Date Member Received Notification; 5. Date Coverage Ends; 6. Did Services Last Less Than 2 days?; and 7. Date of Notice of Medicare Non-Coverage (NOMNC).	N/A		
Medicare Detailed Explanation of Non-Coverage (DENC) Log.	N/A		
Denial Log (including ER denials and behavioral health data, if applicable). Log should include the following: 1) Member Name; 2) Member ID #; 3) Date of Denial Letter;			

4) Type of Denial (medical necessity or benefit .); and 5) Service/Procedure Type.			
Institutionalized Member Log. Log to include the following: 1) Member Name; 2) Member ID#; and 3) Date & Time Service Received	N/A		
End Stage Renal Disease (ESRD) Log: includes all members on chronic dialysis for coordination of benefits. Log to include the following: 1) Member Name; 2) Member ID#; and 3) Date & Time Service Received			

h. Weekly Reporting:

1) Precertifications completed for all non-emergency hospital admissions and elective outpatient procedures, which are listed on the Aetna Precertification List.
2) Reports are to list all service authorizations issued by Delegated Entity for which claims will be processed by Company, to include the following data elements:
   - Member Name
   - Member ID Number
   - Plan Type
   - IPA Authorization Number
   - Authorization start and end date, or actual Date of Service (DOS), if appropriate
   - Referral Type (Outpatient, Inpatient, DME, Specialist Consult, etc.)
   - Diagnosis
   - Procedure name and CPT Code
   - Ordering/Referring Physician
   - Provider/Vendor or Facility Name
   - Admitting Physician and Attending Physician (if applicable)
   - Expected Admission Date (or period authorization is valid for, if applicable)
   - Inpatient Level of Care
   - Inpatient Discharge Date
   - DME (HCPC codes)
   - Home Care (CPT codes; # of visits)
   - Injectables (drug, dosage, etc.)

Delegated Entity shall use its best efforts to submit such reports via electronic means if so requested by Company.

3) Notification of denied inpatient days- notify Aetna Patient Management by designated VSI fax within 48 hours of decision to deny inpatient hospital days. Must include date of admit – admitting physician – dx code –procedure code- discharge date- name of the facility – number of denied days.

i. Other reports, data and information requested from time to time by Company and in a format acceptable to Company, including, but not limited to, timely, accurate and appropriate data and information (including demographics) to enable Company to fulfill NCQA, accrediting organizations, and federal and state regulatory filing requirements and meet the HEDIS standards. Delegated Entity shall use its best efforts to submit such reports via electronic means if so requested by Company;

j. Encounter Data - Delegated Entity agrees to provide Company with complete and accurate encounter data by type of primary care service rendered to Members in the form and manner as specified by Company. Delegated Entity will certify that such encounter data is truthful and complete.

6. Contact Person for Members
Delegated Entity agrees to provide Members with access to an individual in Delegated Entity's organization who is available to receive communications from, and to provide necessary services to, Members relating to Delegated Entity's responsibilities under this Agreement. Delegated Entity agrees and is responsible for communicating with members about the UM process and authorization of care.

7. Surveys
Delegated Entity agrees to conduct regular surveys, no less frequently than annually, involving Members and Participating Providers to determine satisfaction with Delegated Entity's Patient Management activities provided pursuant to this Agreement. Delegated Entity agrees to develop and implement action plans to improve any Patient Management processes which have been identified as problems through the Member or Participating Provider surveys.

8. Notification of Complaints
Delegated Entity agrees to notify Company, within 24 hours of receipt, of any complaints, either oral or written, received by Delegated Entity from Participating Providers and all attorney contacts involving Members.

9. Appeals. Delegated Entity agrees to cooperate with and participate in Company's applicable appeal, grievance and external review procedures (including, but not limited to, Medicare appeals and expedited appeals procedures), provide Company with the information necessary to resolve same, and abide by decisions of the applicable appeals, grievance and review committees.

C. Allocating responsibilities

The mutually agreed-upon document must include the responsibilities of the organization and its delegate in terms specific to their relationship. At a minimum, the document must state which entity, the organization or the delegate, conducts the following activities:

- Adopting criteria.
- Monitoring the quality and timeliness of decisions.
- Preservice decisions, by service.
- Urgent concurrent review and decisions.
- Postservice review and decisions, by service.
- Approvals and denials.
- Appeals.
- Establishing, applying and maintaining pharmaceutical management procedures.
- Evaluating new technology.
- Communicating with members about the UM process and authorization of care
- Managing triage and referral of behavioral healthcare.

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Appendix T

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14 (Q5) EQRO Report

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CoventryCares of Kentucky (CCKY)
Quality Assessment and Performance Improvement: Measurement and Improvement (2014)

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19.1 QAPI Program				
The Contractor shall implement and operate a comprehensive QAPI program that assesses monitors, evaluates and improves the quality of care provided to Members.	Full - Coventry Cares has implemented a QAPI program as outlined in the QI Program Strategy 2012, QI Work Plan, UM Program Description, EQIC Description, Subcommittee and Org Chart, and policies and procedures. Monitoring, evaluating and implementing improvement interventions are also presented in the Annual QI Evaluation Report, which for the last reporting period (2011) was somewhat limited due to recent plan start-up. There has been a great deal of progress since an onsite meeting in October 2012 in implementing several initiatives and improving the quality structure. Quarterly reports, PIP report and committee minutes reveal assessment, monitoring, evaluation and improvement efforts are ongoing.	Full	CCKY has implemented a QAPI program as outlined in the QI Program Description, QI Work Plan and UM Program Description. These include: program goals and objectives, EQIC Description, components of improvement activities, governing body and committee structures/roles, available resources, and process of program evaluation. The 2012 Annual Evaluation provides a comprehensive report on the plan's approach to ensuring quality of care. EQIC committee and reporting subcommittees meet quarterly. Minute summaries (report 21) and PIP reports reveal that assessment; monitoring, evaluation and improvement processes are ongoing. On interview, CCKY described its 2013 goals as: ▪ Improving access and availability ▪ Decreasing inappropriate ED	

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			utilization ▪ Increasing the number of women who complete postpartum visits ▪ Improving care for major depression and ADHD (PIPs) ▪ Decreasing post op infection rates ▪ Addressing substance abuse in pregnancy ▪ Improving continuity of care/decreasing preventable inpatient readmissions (PIP) ▪ Increasing rates of EPSDT services ▪ Developing disease management programs for prevalent chronic diseases.	
The program shall also have processes that provide for the evaluation of access to care, continuity of care, health care outcomes, and services provided or arranged for by the Contractor.	Substantial - Coventry Cares Kentucky's 2012 QI Program Strategy describes the structure and processes that the plan has implemented to monitor, evaluate and improve care and services. The strategy identifies the roles of staff and the committee structure in place to support quality initiatives. The strategy includes monitoring of key indicators such as adverse events and HEDIS measures. The plan also has policies outlining the process for monitoring of grievances and appeals, including quality of care concerns, and access.	Full	CCKY Kentucky's 2013 UM Program Description and QI Program Description describe the structure and processes that CCKY has implemented to monitor, evaluate and improve care and services. The UM Program Description identifies the roles of staff and the committee structure in place to	

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	The QI Program Strategy indicates that the plan will annually review the assessment, analysis and implementation of interventions for member and provider grievances and appeals, cultural factors that impact members, behavioral health issues, utilization and clinical data, access and availability and network adequacy. The Work Plan outlines specific processes underway for evaluating health care outcomes, including HEDIS measures and Healthy Kentuckian measures. The plan has been monitoring monthly HEDIS administrative rates as per onsite staff and quarterly reports. Delegation oversight is included in the QI Program Strategy. The processes for evaluating access with regard to appointment availability are described in P/P PR-006. The plan monitors the availability of provider appointments with secret shopper methodology; PCP calls have begun and specialist calls are scheduled to follow next quarter as per plan onsite staff. Per P/P PR-006, a percentage of PCPs are surveyed quarterly via secret shopper calls, which address urgent care, routine care, preventive care and specialty care. During the onsite meeting in October, the staff indicated that there was some concern about after-hours access and provider availability in rural areas, and that the plan was also monitoring and evaluating ED utilization and Geo Access reports. During the compliance review, onsite staff noted that mapping of urgent care centers was also undertaken. The Utilization Management Program Description		support quality initiatives. The overview of the EQIC committee and QMUM subcommittee includes monitoring and oversight of key indicators such as adverse events, HEDIS measures, and adoption of clinical guidelines. The 2012 Annual Evaluation and the 2013 QI Program Description provide detailed descriptions of the methods used to monitor, evaluate and improve care and services. The QI Program Description identifies the roles of staff and the committee structure in place to support quality initiatives. Results of activities including conducting population analysis, improving access to care, assuring continuity of care, evaluating and disseminating clinical guidelines, monitoring grievances and appeals. Conduct of performance improvement projects is described in the 2012 Annual Evaluation.	

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	describes processes to monitor and report sentinel events and quality of care concerns, ED Utilization and over and under utilization, including pharmacy, hospital readmission and lead screening. The Work Plan indicates tracking of adverse events and member and provider complaints and grievances (category, type intervention and turnaround times). The Summary of Quality Improvement activities report (report 16) notes the top complaints categories. The UM Program Description also notes that Health Services staff identifies members in need of EPSDT services. EPSDT screening rates are being monitored by the plan as documented in quarterly reports, though not noted in the QI Work Plan. The QI Work Plan includes analysis of the health plan population's demographic profile annually, as well as an annual cultural assessment, to prioritize QI activities as recommended by the Executive Quality Improvement Committee (EQIC). This includes high volume diagnoses. The QI Work Plan indicates that CAHPS surveys (adult, child and children with chronic conditions) will be conducted in 2013; annual disease management, case management and customer surveys will also be conducted. Health Risk Assessment (HRA) completion rates are monitored by the plan.		The Work Plan indicates that CCKY conducts annual reviews of the assessment, analysis and implementation of interventions for member and provider grievances and appeals, cultural factors that impact members, behavioral health issues, utilization and clinical data, access and availability and network adequacy. Also, the Work Plan outlines specific processes underway for evaluating health care outcomes, including HEDIS measures. According to the 2012 Annual Evaluation, delegation oversight processes are in place to monitor and evaluate subcontractors. Monthly meetings cover operational concerns. Quarterly oversight meetings are held to review performance, delivery of services, and relevant updates to policies and procedures. All delegates undergo a formal review annually.	

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	Member grievances and Quality of Care concerns have been noted by the plan and in review of files to have some opportunity for improvement with regard to categorization to ensure that all quality of care concerns are appropriately investigated by health care professionals and tracked. **Recommendation for Coventry Cares** The plan should ensure appropriate identification and categorization of all member quality of care concerns, and the plan should further investigate trends of specific categories of quality of care concerns and adverse events when there are sufficient data to analyze by type (e.g. hospital acquired infections). **MCO Response:** None		P/P PR-006 describes the processes for evaluating appointment availability. CCKY monitors the availability of appointments using a secret shopper methodology. Per P/P PR-006, a percentage of PCPs are surveyed annually using secret shopper calls to assess appointment availability for urgent care, routine care, preventive care and specialty care. The Utilization Management Program Description describes processes to monitor and report a variety of quality measures including medical necessity, timely care, consistency in authorization of care, care based on clinical standards, and appropriate cost of care. The Work Plan reflects tracking of adverse events and member and provider complaints and grievances (category, type intervention and turnaround times).	

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			Health Risk Assessment (HRA) completion rates are monitored by the plan. The Annual Evaluation describes several processes to improve care provided to members with results. CCKY conducted two PIPs, developed care management programs for members with chronic and/or behavioral health conditions, implemented interventions to improve rates of postpartum care compliance, and to ensure PCP follow-up after inpatient discharge. CCKY conducted its first CAHPS survey (report 94) to assess member satisfaction. The results revealed opportunities to improve shared decision making, communication between member and providers, overall rating for adult care, overall rating for the plan, and customer service. The plan's provider newsletter provided information on how to improve shared decision making. This topic was also covered in the	

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			Quality Member Access Committee (QMAC) meeting minutes. In 2013, IPRO recommended that CCKY should ensure appropriate identification and categorization of all member quality of care concerns, investigate trends in quality of care concerns and adverse events when there are sufficient data to analyze by type (e.g., hospital acquired infections). The grievance file review reflected a substantial improvement in referrals for potential quality of care concerns (see Grievances tool for details). CCKY conducted a focused study on post-op wound infections. The study revealed that the infections were primarily due to member non-compliance. CCKY initiated a discharge planning program and home health follow-up to address the finding. The prior review revealed that CCKY staff was concerned about	

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			after-hours access and provider availability in rural areas and was also monitoring and evaluating ED utilization and Geo Access reports. In response, CCKY has worked with hospitals to develop urgent care services and recruiting additional urgent care centers: Kroger, CVS Minute Clinic, and some Wal-Mart stores. CCKY is conducting a PIP focused on reducing unnecessary ED utilization. In the prior review, it was noted that although the quarterly reports indicate that CCKY monitors EPSDT screening rates this was not included in the QI Work Plan. On interview, CCKY stated that there is a dedicated work plan for EPSDT initiatives. The EPSDT work plan was reviewed and includes monitoring and follow-up of EPSDT screening rates. **Recommendation for CCKY** CCKY should consider referencing the EPSDT work plan in the QI Work Plan or include as an attachment to the QI Work Plan.	

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The Contractor's QI structures and processes shall be planned, systematic and clearly defined.	Full - The plan has implemented a QAPI program as outlined in the QI Program Strategy, the UM Program Description and various policies and procedures as outlined above. The identified purpose of the QAPI program is to monitor and improve outcomes of care, services, safety, and satisfaction and to promote culturally competent, cost effective delivery of services. The QI Work Plan outlines planned QI activities. The MCO quarterly reports include quality activity updates in an updated QI Work Plan (Report 17, Quality Assessment and Performance Improvement Work Plan). This document identifies quarterly status and activities in greater detail than the QI Work Plan. The QI Work Plan submitted for the review identifies targeted areas of QI activities addressed by the plan, and demonstrates planned monitoring of customer service call answering metrics, pharmacy and UM call answering metrics, UM decision accuracy, Geo Access and appointment availability, member satisfaction, complaints and grievances and appeals turnaround times. Planning for HEDIS reporting in 2013 is included in the Work Plan, and Healthy Kentuckian measures are included as categories, although no planned activities are documented. Delegation oversight, provider satisfaction, Performance Improvement Projects (PIPs) and quarterly reporting are also included as categories in the Work Plan. Many activities have been implemented since the October 2012 onsite meeting.	Full	The plan has implemented a QAPI program as outlined in the QI Program Description, the UM Program Description, and 2012 Annual Evaluation as described above. The stated purpose of the QAPI program is to monitor and improve outcomes of care, services, safety, and satisfaction and to promote culturally competent, cost effective delivery of services. The QI Work Plan outlines planned QI activities. In 2013, IPRO recommended that CCKY consider describing the status and activities completed in the QI Work Plan. The QI Work Plan has been updated to include a comments column where descriptive updates are provided. Additionally, the committee meeting minutes provide detailed information.	

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	Recommendation for Coventry Cares The plan should consider including detailed quarterly status and activities in the QI Work Plan.			
The Contractor's QI activities shall demonstrate the linkage of QI projects to findings from multiple quality evaluations, such as the EQR annual evaluation, opportunities for improvement identified from the annual HEDIS indicators and the consumer and provider surveys, internal surveillance and monitoring, as well as any findings identified by an accreditation body.	Full - As the plan has not yet reported annual HEDIS or Healthy Kentuckian data, QI activities linked to evaluation findings are somewhat limited. The plan has not yet had access to an EQR annual evaluation, accreditation reviews or findings from annual HEDIS indicators and member surveys. The plan does provide evidence of internal surveillance and of metrics including customer service and other call metrics, HRA completion, complaints and grievances and adverse events, and EPSDT screens, as well as utilization metrics. One of the more commonly identified adverse events is documented to be hospital acquired infection, which could be further analyzed regarding root cause when more data are available. Quality of care issues per policy are tracked, analyzed and referred to appropriate committees (QM/UM, Peer Review and Credentialing), and meeting minutes include discussion of potential quality concerns. PIP proposal submissions had strong rationales that included analysis of the plan's utilization metrics showing high ED use and a medication possession ratio	Full	Preparations for NCQA accreditation survey are in process. This is reflected in the EQIC, QMUM, and QMAC meeting minutes and the QI Work Plan. The on-site review will take place on 07/28/14 and 07/29/14 with a look-back period of 6 months (new plan). CCKY provided the HEDIS measure results. The QMUM meeting minutes discuss how lower performing measures will be addressed. A Provider newsletter (Vol 1 Issue 2) describes HEDIS improvement initiatives focusing on preventive health services/ screenings and chronic disease management. Documentation revealed that CCKY intends to target the following measures for improvement: lead screening (LSC), weight assessment and counseling (WCC), well care visits (15 months, 3 – 6 years), prenatal	

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	demonstrating suboptimal adherence to antidepressants. HRA completion rates were noted to be low, and the plan has implemented a work group to address this issue with their vendor as per onsite staff. This is an important initiative, since the HRA is an important component of plan activities, such as outreach to smokers for cessation assistance. EPSDT rates were noted to be low, and the plan has implemented an EPSDT toolkit, EPSDT training modules for providers, feedback regarding members missing screens and an EPSDT audit tool. The plan conducted a medical record audit that revealed BMI and Advance Directives to be areas with opportunity for improvement; this feedback was given to providers. The plan identified several interventions that would be undertaken in response to provider survey results. The plan has implemented an asthma program for providers. MCO quarterly reports indicate that an action plan will be implemented for Geo Access if needed. The plan indicated that a contract was initiated with a Federally Qualified Health Center (FQHC) to improve access, and other initiatives including increasing urgent care center access and surveying providers regarding accepting members out		and postpartum care (PPC) and a variety of chronic care measures (e.g., CDC, CBP, among others). The QI Program Description outlines the process for linking evaluation data from various sources to QI initiatives. The Work Plan includes the rationale for activity selection, which include accreditation, contract requirements, EQRO review, or delegation oversight. The 2012 Annual Evaluation identifies hospital acquired infections (HAI) as the most commonly occurring adverse event. HAIs are tracked and reports are reviewed monthly by Medical Director and QMUM reviews these events bi-annually. Corrective action is implemented. Quality of care issues per policy are tracked, analyzed and referred to appropriate committees (QM/UM, Peer Review), and meeting minutes include	

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	of panel.		discussion of potential quality concerns. 2014 PIP proposal focuses on reducing hospital readmissions. 2013 PIPs focus on identification and treatment of major depression and reduction of ED utilization. All PIP indicators demonstrate substantial opportunity for improvement. 2013 was the first year that CCKY administered the CAHPS survey. The CAHPS survey report (report 94) identified the following as opportunities for improvement: shared decision making, overall rating for adult care, overall rating for plan, and provider communication with members. An internal workgroup discussed barriers and interventions were developed. The provider satisfaction survey had a 24% response rate and revealed the following opportunities for improvement: resolution of inquiries,	

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			claims/payment process, and prior authorizations process. Interventions were not discussed. **Recommendation for CCKY** It was suggested that CCKY consider including HEDIS adolescent well care (AWC) and frequency of prenatal care (FOP) among the measures targeted for improvement since the majority of the MCO's membership is children and women of child-bearing age.	
The QAPI program shall be developed in collaboration with input from Members.	Full - The updated QI Program Strategy updated 11/26/12 notes that member input will be solicited in various ways including through satisfaction surveys. The CAHPS survey is underway at the time of the review. The plan cites voiced concerns of members regarding barriers to care in the rational for their Performance Improvement Project (PIP) regarding Emergency Department (ED) utilization. The QI Program Strategy identifies the Quality and Member Access Committee (QMAC) as a subcommittee of the Executive QI Committee, and the purpose of the committee is to obtain feedback from members on marketing materials, customer service, network access, benefit interpretation, and the health plan overall. While the first QMAC meeting in April 2012 was informational, minutes from subsequent meetings in September and December 2012 reflect these activities and input from	Full	2013 was the first year that CCKY administered the CAHPS survey. The CAHPS survey report (report 94) identified the following opportunities for improvement: shared decision making, overall rating for adult care, overall rating for health plan, and provider communication with members. An internal workgroup discussed barriers and interventions were developed. The QI Program Description and CCKY quarterly reports identify the Quality and Member Access	

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	members on the QAPI program. Discussions included an overview of QI and HEDIS measures, review of the Member Handbook and Provider Directory, and discussion of PIPs. Members provided input on the plan's website, and a question and answer period is documented.		Committee (QMAC) as a subcommittee of the Executive QI Committee. The purpose of the committee is to obtain feedback from members on marketing materials, customer service, network access, benefit interpretation, and the health plan overall. The meetings occur quarterly by region. Meeting minutes reflect conduct of the stated activities and input from members on the QAPI program. Discussions included an overview of QI Program Description and Work Plan, HEDIS measures, NCQA process, CAHPS survey, and review of the Member Handbook, Provider Directory, and formulary. Members expressed concerns over barriers to access to dental care. These concerns were brought to the EQIC committee as documented in EQIC meeting minutes. Upon interview, CCKY described the actions taken to evaluate and address the member concerns regarding dental access. Avesis,	

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			the dental vendor, conducted a GeoAccess evaluation which revealed that access was adequate and that member perception may be the root of the complaints. Avesis also undertook an initiative to link members to network orthodontists.	
The Contractor shall maintain documentation of all member input; response; conduct of performance improvement activities; and feedback to Members.	Full - Minutes were provided for QMAC meetings from 4/25/12, 9/12/12 and 12/19/12. Minutes included topics discussed as noted above, including Performance Improvement Projects (PIPs) and member comments. Member-voiced concerns are noted in the rationale for the PIP proposal as noted above, and the plan is in the process of conducting CAHPS surveys. The plan tracks member concerns (complaints and grievances) as noted in the Work Plan, and member complaints and grievances receive acknowledgement/resolution letters. The plan included a customer service survey response in their complaints files. The member had forwarded a complaint regarding medication coverage, and the plan responded to this member's input. As per the QI Program Strategy, members can access a copy of the QI Program Strategy through Customer Service.	Full	QMAC minutes described the activities and discussion of the committee as stated previously. In addition to the member concerns about access to dental care, issues with medical appointment availability and availability of interpreters were expressed. CCKY staff at the QMAC meetings encouraged members to file grievances and use the 24 hour Nurse line when needed. Members can access a copy of the QI Program Strategy through Customer Service and on the website. During the onsite review, CCKY described efforts to expand its provider network and monitoring of access to care in each region.	

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			CCKY also explained that the MCO uses a language line type service and has interpreters available to attend inpatient visits and assist members in the hospital. CCKY described an issue related to translation of Burmese, but it was a knowledge issue and was addressed. Members' primary language other than English is Spanish. The call center located in Houston is staffed with English/Spanish bilingual associates.	
The Contractor shall have or obtain within 2-4 years and maintain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line.	NA - The plan is preparing for NCQA accreditation, and the QI Work Plan notes an anticipated NCQA accreditation as of 2014. The plan is involving all departments in preparation, and EQIC minutes reflect ongoing preparation for accreditation.	Not Applicable	CCKY is preparing for its initial NCQA accreditation survey and this is reflected in the EQIC, QMUM, and QMAC meeting minutes and the QI Work Plan. Preparations have included mock audits. The accreditation survey is scheduled for 07/28/14 and 07/29/14. MHNet, the BH vendor, hold both URAC and NCQA accreditation.	
The Contractor shall provide the Department a copy of its current certificate of accreditation together	NA - Not applicable; the plan has not yet begun the NCQA accreditation process.	Not Applicable	NCQA accreditation survey is pending.	

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with a copy of the complete survey report every three years including the scoring at the category, Standard, and element levels, as well as NCQA recommendations, as presented via the NCQA Interactive Survey System (ISS): Status, Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History.				
Annually, the Contractor shall submit the QAPI program description document to the Department for review by July 31 of each contract year.	Full - The QAPI program description was outlined in the document QI Program Strategy 2012, dated 7/25/12 and updated 11/26/12; the strategy was submitted to DMS 7/30/12 as per the QI Work Plan and EQIC minutes.	Full	Work Plan indicates the QI Program Description was submitted in July 2013. May 22, 2013 EQIC meeting minutes indicate that the description was sent to DMS by the time of the EQIC meeting.	
As the Contractor will provide Behavioral Health services, the Contractor shall integrate Behavioral Health indicators into its QAPI program and include a systematic, ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members.	Full - The QI Program Strategy indicates that members' behavioral health needs are provided for and behavioral health and physical health services are coordinated to improve identification and care for members with behavioral health needs. Behavioral health services are integrated into the plan and QAPI program, and behavioral health and physical health are coordinated at the plan level and individual case level. Administration and management of behavioral health services (mental health and substance abuse) is undertaken by MHNet, an NCQA accredited Managed Behavioral Health Care Organization	Full	MHNet, an NCQA accredited Managed Behavioral Health Care Organization (MBHO) and CCKY subsidiary administers and manages behavioral health services (mental health and substance abuse). The QI Program Description indicates that behavioral health and physical health services are coordinated to improve identification of and care	

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	(MBHO). MHNet is Coventry owned. Behavioral health quality improvement activities and utilization management are delegated to MHNet, but behavioral health and physical health actively work together on PIPs and other initiatives (e.g. substance abuse among pregnant women and behavioral health-physical health continuity of care). The plan and MHNet hold regular operational meetings to monitor performance as per quarterly reports. There is behavioral health representation on the Executive Quality Improvement Committee (EQIC) and Quality Management/Utilization Management (QM/UM Committee. EQIC and QM/UM minutes include discussion of behavioral health issues, such as adoption of behavioral health guidelines. MHNet behavioral health care advocates are co-located at the health plan to integrate treatment and case management activity, and they interact with physical health case managers to coordinate care and address comorbidities. The collocation also facilitates referrals between behavioral health and physical health. The QI Program Strategy notes that members are surveyed for mental health status in multiple existing quality programs. There are weekly Coventry Cares/MHNet team meetings and case management rounds, which also offer opportunity for nurses to interact with MHNet staff and Medicaid pharmacists as per the Annual Evaluation.		for members with behavioral health needs at both the plan and individual member level. Behavioral health services are integrated into the QAPI program. Behavioral health QI and UM activities are delegated to MHNet, but behavioral health and physical health staffs actively collaborate on PIPs and other initiatives (e.g. substance abuse among pregnant women and behavioral health-physical health continuity of care). CCKY and MHNet hold regular operational meetings to monitor performance. Behavioral health has representation on the Executive Quality Improvement Committee (EQIC) and Quality Management/Utilization Management (QM/UM) Committee. EQIC and QM/UM meeting minutes demonstrate discussion of behavioral health issues, such as adoption of behavioral health clinical guidelines.	

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	The plan monitors behavioral health utilization indicators as per quarterly reports, and is working to clarify other indicators. The plan conducted behavioral health member surveys in 2012.		MHNet behavioral health care advocates are co-located at the health plan to integrate treatment and case management activity, and to coordinate with physical health case managers. The collocation also facilitates referrals between behavioral health and physical health. The 2012 Annual QI Evaluation indicates that there is common coordination of care screening and referral form for formal requests. This was seen in the PH/BH file review. The QI Program Strategy indicates that members are surveyed regarding behavioral health needs across the existing quality programs. The 2012 Annual Evaluation describes weekly CCKY/MHNet team meetings and case management rounds offer additional opportunity for CCKY and MHNet staffs to interact. Finally, CCKY monitors behavioral	

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			health utilization indicators and there is MHNet input for the 2013 and 2014 PIPs.	
The Contractor shall collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Member's overall care.	Minimal - The plan documented working on behavioral health and physical health coordination initiatives, including substance abuse among pregnant women and depression management by PCPs. Onsite staff discussed tracking of referrals, PCP prescribing and depression screening. The plan did not provide reports of indicators relevant to behavioral health/physical health integration. The annual evaluation notes priorities for 2012 to include oversight of delegated services, including monitoring and improvement of behavioral health care delivery. **MCO Response:** CoventryCares understands the importance of integrating behavioral health with physical health, and is committed to this important health initiative. CoventryCares is collaborating with its behavioral health subcontractor, MHNet, to ensure optimal outcome and continuity of care in the member's treatment related to major depression, pregnancy and drug abuse. This is partially accomplished through integration of MHNet and CoventryCares Case Managers in case rounds for those members needing both physical and behavioral health assistance. A focus study to address substance abuse in pregnant women and prevent medical conditions among newborns was proposed in late 2012. This is a collaborative project	Full	The QI Program Description reveals that behavioral health (BH) QI program is integrated into the plan's QI program. MHNet provides regular representation in QI committees and workgroups. The plan monitors BH services through annual oversight audits. Major Depression PIP described BH and PH grand rounds meet weekly to assess high-risk patients with both behavioral and medical concerns in order to develop a plan of care. There is also a joint tracking tool used by plan case managers and MHNet. The resulting care coordination may have contributed to demonstrated improvement during the interim measurement. MHNet is also involved in the ED utilization PIP through joint case management services care coordination and development of	

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	between Case Management, MHNet (behavioral health vendor), Medical Affairs, and Quality Improvement (QI). Prenatal substance abuse is a major public health concern nationally, and more specifically in Kentucky, and has potentially severe consequences for the user and their child. Substance abuse is defined as a pattern of excessive use of an illicit substance, such as drugs (marijuana, cocaine, heroin, methamphetamines, etc.), alcohol or nicotine and the over or misuse of prescription medications. Baseline data has been collected and community resources beyond case management are being explored. A workgroup has been established; goals and objectives have discussed and proposed. The full study proposal has been written and discussed to be implemented in year 2013. Please refer to attached proposal titled, "Focus Study-Substance use in pregnancy final 4.18.13." In addition, case rounds that include MHNET and case management personnel for members having both physical and behavioral health concerns began in May 2013. Minutes are kept of the case rounds.(Minutes are available upon request). Our Performance Improvement Project (PIP) for Major Depression and Antidepressant Medication Management and Compliance is also working to address this issue and has progressed significantly in 2013. Please note, this PIP was updated and approved by the Department for Medicaid Services in December 2012. As a result, just a small data set was available for the EQRO review period. The interventions, monitoring and evaluation are		case management tool. As per the 2012 Annual Evaluation, MHNet and CCKY case managers meet together for case rounds for those members requiring BH and PH services. The BH and PH case managers also refer members as needed for PH and/or BH issues. Completed referral forms were seen in the BH/PH Coordination file review. QMUM meeting minutes reflect joint reporting from case managers and MHNet. QMUM also reviews BH collaborations such as prevention program focused on ADHD, Anxiety, Depression in the Older Adult, and post partum depression.	

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	occurring in 2013. In coordination with our behavioral health vendor, MHNet, Case Management (CM), Provider Relations, the Pharmacy Director and the Medical Director are working on the following activities and initiatives since January of 2013: --Interdepartmental workgroup meetings started in December 2012 and are ongoing monthly. Minutes are taken and participants include QI, Outreach, Provider Relations, Case ManagementHealth Services, Medical Affairs and MHNet, our behavioral health vendor. (Minutes available upon request). --The Academic literature search and strategies (PIP intervention #8) were implemented in collaboration with the Pharmacy Director and QI staff in January 2013. The goal of the collaboration is to develop strategies and identify literature to educate providers and assist them with educating their members regarding the adherence, response time to the medication, and the risks of premature discontinuation. --A targeted letter and brochure for 236 members was mailed in late January 2013 on the importance of following their treatment plan. Members were identified using the 2013 HEDIS methodology defined as members 18 years and older with a diagnosis of major depression and were newly treated with antidepressant medication. --The CoventryCares of Kentucky website is being enhanced to better educate members. The website will			

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	include a Behavioral Health a link to the National Institute of Mental Health (NIMH) website for depression. CoventryCares will use the member tab to provide members with educational information regarding the identification, diagnosis, and importance of management of major depression. --A PIP document library has been created. The library contains all the documents relating to the Major Depression Disorder (MDD) PIP (i.e. approved provider and member correspondence, reports etc.) --Kentucky transportation information has been distributed to all employees and members of CoventryCares and MHNet. The transportation resource information will assist members with their transportation needs. --The Major Depression Disorder (MDD) PIP Intervention Tracking Tool has been created. The PIP Intervention Tracking Tool is a "living document" providing a current snapshot of all PIP activities tracking the internal flow process for referrals from CoventryCares Case Management (CM medical) to MHNet (behavioral services). Tracking will be ongoing. Updates will be presented to the MDD workgroup monthly. --Ongoing collaboration between CoventryCares and MHNet included the development of a tool for tracking mailings to members who receive education regarding			

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	depression and post partum depression. Results of the trackings are presented to the MDD workgroup monthly. --Development of a member educational packet to be mailed to members identified in the above tracking report. The packet includes a targeted member letter, *Following Your Treatment Plan* and *First Aid Tips* brochures, and a non-emergency room facts magnet. --Collaborated with the Quality Management and Compliance Committee (QMAC) for educating members in the community about major depression. This included a meeting in Georgetown, Kentucky on 3/31/2013. The MHNet keynote speaker's topic was "Mental Health Medication and Therapy." --HEDIS reports and Medication Possession Ratio rates evaluated monthly and will be reported in the next state quarterly report (please refer to report 19) --A total of 841 letters with brochures for following your treatment plan were sent to members in May 2, 2013, and 130 mailers to non-compliant members on May 30, 2013. We will continue our interventions and evaluation per our PIP work plan (please refer to PIP interventions outlined in the proposal), and a full evaluative report will be submitted to the state in September 2013 with HEDIS results.			

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19.2 Annual QAPI Review				
The Contractor shall annually review and evaluate the overall effectiveness of the QAPI program to determine whether the program has demonstrated improvement in the quality of care and service provided to Members. The Contractor shall modify, as necessary, the QAPI Program, including Quality Improvement policies and procedures; clinical care standards; practice guidelines and patient protocols; utilization and access to Covered Services; and treatment outcomes. The Contractor shall prepare a written report to the Department, detailing the annual review and shall include a review of completed and continuing QI activities that address the quality of clinical care and service; trending of measures to assess performance in quality of clinical care and quality of service; any corrective actions implemented; corrective actions which are recommended or in progress; and any modifications to the program. There shall be	Full - The Annual Evaluation of the Quality Improvement Program (Annual Review of Activities 11/1/11-12/31/11) was conducted after the plan had been in operation for two months, and is included in the Work Plan as an activity that will be conducted at the end of 2012. The 2011 Annual Review is dated 7/31/12. This evaluation includes an analysis of KY and Coventry population demographics. For the health plan, children ages 18 or less comprised 61%of the population, special needs (SSI) 17.8% and dual eligible 13%. An analysis of high volume episodes by diagnosis and place of service is also included; the top 20 diagnoses for high volume episodes include hypertension, asthma, diabetes and COPD. These conditions were therefore targeted for disease management. High risk OB was also identified as high volume. Abandoned calls and speed to answer were reported in the evaluation, and were noted to exceed the target in December; this was attributed to new staff and start up, and continued monitoring was planned. There were few other indicators to report, given the short time that the plan had enrolled members; few complaints and grievances had been reported. Some examples of adverse events were included in the evaluation, and it is noted that these will be tracked and trended. **Recommendation for Coventry Cares**	Full	The 2012 Annual Evaluation reviews activities for the period between Jan 1, 2012 to December 31, 2012. The evaluation provides an in depth overview of the QAPI program. It includes a population analysis, which reveals that the plan covers about 24% of the entire KY Medicaid population. Children ages 18 years and under represent 64% of the membership. Linguistics analysis showed 3,000 Spanish-speaking members in their database. The plan, in turn, developed Spanish tag lines on all member mailings and translated mailers to each identified Spanish –speaking member. Translation services are offered through the toll free phone number as described in the Member Handbook. Language assistance services, TDD services, and person-to-person interpretation services are also available.	

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evidence that QI activities have contributed to meaningful improvement in the quality of clinical care and quality of service, including preventive and behavioral health care, provided to Members. The Contractor shall submit this report by July 31 of each contract year.	The plan should consider root cause analysis of common adverse events.		High volume episode reporting is reported as a way to identify clinical priorities. The top 25 diagnoses included ADHD, COPD, acute URI, asthma, low back pain, diabetes and hypertension. The plan compared the high volume diagnoses with those of the high volume ED visits and found commonalities that will be addressed in the 2013 PIP – ED Utilization. The Disease Management programs focus on 6 diseases: asthma, diabetes, coronary artery disease, chronic kidney disease, heart failure, and COPD. An ADHD focused PIP was designed in collaboration with MHNet. Access to Care was analyzed. This included a review of customer service, language line access, 24 hour nurse line use, appointment wait times, and network/geographic availability. As a result, CCKY conducted additional staff training, evaluated of McKesson (nurse line vendor)	

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			performance, improved the disease management program, changed the vendor used for the secret shopper Access/Availability (A/A) survey, and recruited additional providers in rural regions. Member satisfaction was assessed using the CAHPS survey. Results were not available at the time that CCKY prepared the 2012 QI program evaluation report. Grievances were analyzed. The top categories were: customer service, quality of care, and quality of service. CCKY planned to address these issues with additional training and education, a new electronic Grievance/Appeal (G/A) filing system, and a new Quality Check program for grievance processing. Evaluation of Clinical Care included a review of UM telephone access and CCKY met the metrics. To maintain the performance, CCKY developed a monitoring program to evaluate the representatives'	

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			accuracy, courtesy and responsiveness. CCKY noted a decrease in authorization requests which was attributed to refining the prior authorization list and educating providers. An analysis of bed days prompted CCKY to promote timely discharge and enhance the High Risk OB and Case Management programs. UM denials were reviewed. This revealed the need to direct members to in-network providers. Inter-rater reliability testing of UM reviewers was found to be very good and was followed by reinforcing the application and interpretation of UM criteria. CCKY planned to use monthly HEDIS measure performance reports to inform ongoing interventions. For services not assessed by HEDIS, the Kentucky-specific measures were to be used. CCKY planned to initiate provider feedback regarding HEDIS	

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			performance and non-compliance with guidelines through the provider targeted website – directprovider.com. Two PIPs were in process during 2012. The topics were priority areas for the state, Antidepressant Medication Management and Compliance, and Decreasing Non-emergent/ Inappropriate ED Utilization. CCKY formed multidisciplinary workgroups to design and monitor the PIP interventions. These workgroups included representatives of MHNet (BH vendor). The PIP results were not available at the time of the 2012 CCKY QI program evaluation report. Due to the first HEDIS and performance measure reporting to occur in 2013, there was no Pay-for-Performance program. In 2012, CCKY identified over 31,000 members for their disease management programs. The effectiveness and satisfaction of	

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			the disease management programs will be evaluated in 2013. Medical record audit prompted CCKY to educate and encourage providers to promote advanced directives and practice BMI assessment and documentation. Follow-up audits are scheduled in 2013. The 2012 Annual Evaluation describes delegation oversight findings and corrective action as necessary. The plan engages vendors for behavioral health, chiropractic, dental, pharmacy, 24 hour nurse line, and pain management services. They also use vendors for external review, and radiology utilization management services. Quality of care issues and adverse events are monitored monthly. The highest rate was seen in the second quarter. This may have been the result of CCKY implementing a new reporting	

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			system. Hospitals had the highest number of quality referrals due to surgical site infections. CCKY documented several activities to ensure continuity and coordination of care. MHNet is highly integrated in activities that involve BH concerns. A provider satisfaction survey was fielded in 2012. The survey demonstrated that areas of concern included: resolution of inquiries, claims payment process, service, and the authorization process. Interventions include: training call center staff, educating providers on policies and procedures, promoting directprovider.com, publishing information in the provider newsletter, and increasing outreach visits to providers. The Health Outcomes Survey is planned for 2013.	
21.3 External Quality Review				
The Contractor shall provide information to the EQRO as	Substantial - As per the plan's 2012 QI Program Strategy, Coventry participates in annual reviews and provides	Substantial	The QI Program Description states that the plan will actively	As Coventry transitions to the Aetna platform our annual review

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requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Parts 433 and 438.	access to the site, information, documentation and dates for review to the EQRO. The plan provided most of the requested information for the annual compliance review; some information, such as Health Risk Assessment files, was not provided for review onsite or immediately thereafter. The plan provided PIP proposals and revised proposals as requested for PIP validation. Though not yet applicable, the corporate plan also reviews the annual EQRO evaluation, provides comments for improvement and implements EQR recommended corrective actions as per the Program Strategy. **Recommendation for Coventry Cares** The plan should provide requested documentation in a timely fashion for future reviews.		participate in an external independent review performed by the designated External Quality Review Organizations (EQRO), including providing the EQRO with access to site, information, documentation and data. Following an EQRO review the CCKY will review the EQRO report, provide comments for improvement, and implement corrective actions as recommended by the EQRO. During the onsite review, CCKY was cooperative and helpful in providing documentation requested for clarification and in answering related questions. CCKY posted all follow-up documentation timely, most during the onsite. For some of the file reviews (Credentialing, HRA, Service Plans) some evidence/supporting documentation was not in the files or available. See the respective tools for detailed findings.	of policies and procedures will ensure staff is informed of requirements for timely access to files and timeliness of delivery to the EQRO. CCKY shall document its efforts to obtain files and any challenges that may inhibit the plan from receiving the files.

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			In the prior review, there were some issues related to timely submission of pre-site documentation. IPRO recommended that CCKY provide the requested documentation in a timelier manner. For the current review, the pre-site documentation was received timely. **Recommendation for CCKY** In the future, CCKY should provide all supporting documentation for the file reviews whether it is maintained at the local site or at other locations. If documentation is pursued but not provided by other parties, CCKY should document the efforts taken to obtain the information.	
The Contractor shall cooperate and participate in the EQR activities in accordance with protocols identified under 42 CFR 438, Subpart E. These protocols guide the independent external review of the quality outcomes and timeliness of, and access to, services provided by a	Full - As per the QI Program Strategy, the plan actively participates in EQR activities. The health plan cooperated and participated in the evaluation of quality program review in October 2012, annual compliance review 2013 and the PIP validation process. The plan had key staff available for the onsite review, and staff was actively engaged In the process. The plan submitted PIP proposals, and engaged in conference calls to discuss findings and	Full	The QI Program Description states that CCKY will actively participate and make available all data, clinical and other records/reports to the state Medicaid agency for EQR activities. CCKY cooperated and participated	

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Contractor providing Medicaid services. In an effort to avoid duplication, the Department may also use, in place of such audit, information obtained about the Contractor from a Medicare or private accreditation review in accordance with 42 CFR 438.360.	recommendations from review of the PIP proposals, and revised the PIPs based on recommendations.		in the current compliance review, PIP validation, PM validation, requests for data and records for focused studies and other EQRO tasks and was cooperative with recommendations and suggestions. For the onsite review, staff was readily available, helpful and responsive.	
21.4 EQR Administrative Reviews				
The Contractor shall assist the Department and the EQRO in identification of Provider and Member information required to carry out annual, external independent reviews of the quality outcomes and timeliness of on-site or off-site medical chart reviews. Timely notification of Providers and subcontractors of any necessary medical chart review shall be the responsibility of the Contractor.	Substantial - As per the QI Program Strategy and P/P QI-002, the plan provides information as requested for EQR activities. The plan provided most information requested as noted above; however, Health Risk Assessment member files that were requested were not provided for review. **Recommendation for Coventry Cares** The plan should ensure complete submission and availability of requested documentation.	Substantial	As noted previously and in the QI Program Description, CCKY provided pre-site documentation as requested for the compliance review. There were some issues, documented above, with file review documentation (Credentialing, HRA, and Service Plans). CCKY also cooperated with submission of data, records, and documents for other EQR activities, including PIP validation, PM validation, and focused studies.	As Coventry transitions to the Aetna platform our annual review of policies and procedures will ensure staff is informed of requirements for timely access to files and timeliness of delivery to the EQRO. CCKY shall document its efforts to obtain files and any challenges that may inhibit the plan from receiving the files.

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			In the prior review, there were some issues related to timely submission of pre-site documentation. IPRO recommended that CCKY provide the requested documentation in a timelier manner. For the current review, the pre-site documentation was received timely. **Recommendation for CCKY** In the future, CCKY should provide all supporting documentation for the file reviews whether it is maintained at the local site or at other locations. If documentation is pursued but not provided by other parties, CCKY should document the efforts taken to obtain the information.	
The Contractor shall assist the EQRO in competing all Contractor reviews and evaluations in accordance with established protocols previously described.	Substantial - As above, the plan assisted in EQRO reviews and evaluation. Some requested files and documents were not provided. **Recommendation for Coventry Cares** The plan should ensure complete submission and availability of requested documentation.	Substantial	As described above, CCKY assisted in EQRO reviews and evaluation. There were some issues related to requested files. In the prior review, there were some issues related to timely submission of pre-site	As Coventry transitions to the Aetna platform our annual review of policies and procedures will ensure staff is informed of requirements for timely access to files and timeliness of delivery to the EQRO. CCKY shall document its efforts to obtain files and any

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			documentation. IPRO recommended that CCKY provide the requested documentation in a timelier manner. For the current review, the pre-site documentation was received timely. **Recommendation for CCKY** In the future, CCKY should provide all supporting documentation for the file reviews whether it is maintained at the local site or at other locations. If documentation is pursued but not provided by other parties, CCKY should document the efforts taken to obtain the information.	challenges that may inhibit the plan from receiving the files.
21.5 EQR Performance				
If during the conduct of an EQR by an EQRO acting on behalf of the Department, an adverse quality finding or deficiency is identified, the Contractor shall respond to and correct the finding or deficiency in a timely manner in accordance with guidelines established by the Department and EQRO. The Contractor shall:	Full - The initial PIP proposals were not accepted by DMS, and the plan revised the proposals as per the timeline established during conference calls. The plan has not yet had opportunity to respond to findings of the compliance review.	Full	For the prior compliance review, CCKY provided responses for findings that were less than fully compliant, as required. In addition, CCKY revised its PIP proposals in response to EQR recommendations.	

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A. Assign a staff person(s) to conduct follow-up concerning review findings;	NA - EQR compliance review findings have not yet been provided to the plan. The assignment of a staff person to conduct review findings follow-up is included in P/P QI-002. Responsible parties for PIP reviews were identified.	Full	CCKY designated staff liaisons for follow-up for the EQR activities and was cooperative with recommendations and requests.	
B. Inform the Contractor's Quality Improvement Committee of the final findings and involve the committee in the development, implementation and monitoring of the corrective action plan; and	NA - EQR compliance review findings have not yet been provided to the plan. As per P/P QI-002, the Quality Manager informs the Quality Management Committee of EQRO findings and will develop, implement and monitor a corrective action plan.	Full	The QI Work Plan and quarterly reports document that the Quality Manager informs the EQIC Committee of EQRO findings and develops, implements and monitors a corrective action plan. The QI Work Plan indicates that the prior compliance review report was shared with EQIC in May 2013.	
C. Submit a corrective action plan in writing to the EQRO and Department within 60 days that addresses the measures the Contractor intends to take to resolve the finding. The Contractor's final resolution of all potential quality concerns shall be completed within six (6) months of the Contractor's notification.	NA - This is included in the QI Program Strategy and P/P QI-002. The plan has not yet had opportunity to respond to findings.	Full	The QI Program Description states that CCKY will submit a Corrective Action Plan, within the timeframes established by the EQRO, to resolve any performance or quality of care deficiencies identified during any ongoing monitoring and assessment activities of the EQRO. CCKY acted accordingly for the prior compliance review.	

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D. The Contractor shall demonstrate how the results of the External Quality Review (EQR) are incorporated into the Contractor's overall Quality Improvement Plan and demonstrate progressive and measurable improvement during the term of this contract; and	NA - The QI Program Strategy describes the plan's participation (corporate participation is noted) in the annual external quality review, and includes implementation of corrective actions as per recommendations. The QI Work Plan includes cooperation with EQR activities. The QI Work Plan notes resubmission of PIP proposals based on EQR recommendations and formation of interdepartmental work groups to address PIPs. The plan has not yet had opportunity to review annual compliance review findings.	Full	The QI Program Description states that CCKY will participate in the annual external quality review, including implementing corrective actions as per recommendations. The QI Work Plan incorporates cooperation with EQR activities. The QI Work Plan includes resubmission of PIP proposals based on EQR recommendations and formation of interdepartmental work groups to conduct PIPs. CCKY has followed EQRO recommendations related to PIPs, focused studies, and compliance findings.	
E. If contractor disagrees with the EQRO's findings, it shall submit its position to the Commissioner of the Department whose decision is final.	NA - This is included in P/P QI-002. The plan has not had opportunity to review EQRO findings for the annual compliance review.	Not Applicable	Not applicable – CCKY has not indicated disagreement with EQRO findings.	
19.3 QAPI Plan				
The Contractor shall have a written QAPI work plan that	Full - The plan submitted the CoventryCares of Kentucky QI Work Plan 2012 (the Work Plan) final 7/25/12 updated 11/27/12.	Full	CCKY submitted the CCKY QI Work Plan 2013 (the Work Plan).	
outlines the scope of activities and	Full - Initiatives are listed in the Work Plan, with rationale	Full	The QI Work Plan lists activities	

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	and description of methodology for conducting and measuring initiatives.		with rationale for selection and corresponding NCQA accreditation requirement. The QI Work Plan includes objectives, list of tasks, responsible staff, and benchmarks, due dates, status, and comments on project status. **Recommendation for CCKY** CCKY should include all action plans described in the Annual Evaluation, listing each by topic.	
the goals,	Full - The Work Plan includes specific goals.	Full	The QI Work Plan includes specific goals.	
objectives, and	Full - The Work Plan includes specific objectives.	Full	The QI Work Plan includes specific objectives.	
timelines for the QAPI program.	Substantial - Reporting frequencies are included in the Work Plan. Dates are included in the Work Plan, but it is not clear whether these are target dates for completion or dates that activities were completed. **Recommendation for Coventry Cares** The Work Plan should include anticipated timelines for the Program as well as completion dates. Responsible parties are identified in the work plan.	Substantial	The QI Work Plan incorporates start and due dates but it is not clear whether these are the target dates for completion or completion dates. The work plan does not include the dates when required reports were submitted to DMS and the internal committees. For the prior review, IPRO recommended that CCKY include	The work plan for 2014 captures a Start date and a due date. A column for 'Completion Date' has been added for clarity at the request of IPRO. Additionally, the comments section will outline the report submission date to DMS and a report schedule will be attached to the work plan to capture specific deliverable dates for QMUM and EQIC reports.

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			timelines and completion dates in the QI Work Plan. As noted above, this was partially addressed as it is not evident if the dates are target or actual completion dates. **Recommendation for CCKY** CCKY should label the dates as start, target, and actual completion dates and include submission dates for the required committee reports and DMS.	
New goals and objectives must be set at least annually based on findings from quality improvement activities and studies, survey results, Grievances and Appeals, performance measures and EQRO findings.	NA - The Work Plan was finalized 7/25/12, and activities and status are updated quarterly in quarterly reports. There are few findings available as of yet, as the plan has not yet reported annual measures, conducted surveys or received findings from the EQRO review. The QI Program Strategy indicates that recommendations will be developed based on annual review of the QAPI program. Committee minutes provide evidence of tracking and trending grievances and appeals and adverse events. As per EQIC minutes, the plan has set goals for appeal overturn rates. The plan is monitoring monthly HEDIS indicators, although annual results are not yet available to set goals. Interventions were outlined in response to Provider Survey results.	Full	The 2012 Annual Evaluation includes revised goals, objectives, and interventions for the coming year. Committee minutes provide evidence of tracking and trending quality improvement activities, survey results, grievances and appeals, performance measures, and adverse events. Since CCKY will report its first year HEDIS rates in 2014, there is no information on QI activities related to HEDIS performance in the 2012 QI Evaluation. However, CCKY provided other documents onsite	

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			that described the HEDIS measures being targeted for improvement and the related initiatives.	
The Contractor is accountable to the Department for the quality of care provided to Members. The Contractor's responsibilities of this include, at a minimum: approval of the overall QAPI program and annual QAPI work plan;	Full - As per the QI Program Strategy, the Board of Directors has delegated oversight of the QI Program to the Executive Quality Improvement Committee, and responsibilities include review and approval of the QI Program Description and Work Plans, including updates to Work Plans, as per the QI Program Strategy and EQIC Responsibilities-2012 document provided by the plan. The EQIC approved the QI Program Strategy and QI Work Plan on 7/25/12 as reflected in minutes and the QI Work Plan. Discussion of the updated QI Work Plan is also evident in committee minutes and the Work Plan.	Full	The QI Program Description states that the Board of Directors is responsible for the quality of care and delegates oversight of the QI Program to the EQIC. The EQIC responsibilities include review and approval of the QI Program Description and QI Work Plans, including updates. Discussion and approval of the QI Work Plan and QI Program Description is evident in EQIC minutes.	
designation of an accountable entity within the organization to provide direct oversight of QAPI;	Full - The Board of Directors of Coventry Health and Life Insurance Company is ultimately responsible for oversight of the QI Program of Coventry Cares of Kentucky. As per the QI Program Strategy, the board has delegated oversight of the plan's Quality Improvement and Management program to the Executive Quality Improvement Committee (EQIC). The EQIC reports to the Board of Directors, is chaired by the Chief Executive Officer and includes members of senior leadership. The EQIC implements, monitors and evaluates the effect of quality improvement policies, procedures and programs; quality of care and services; credentialing; utilization	Full	As indicated above, the Board of Directors of Coventry Health and Life Insurance Company is ultimately responsible for oversight of the QI Program of CCKY. The QI Program Strategy states that the Board of Directors (BOD) delegates oversight of the Quality Improvement and Management program to the Executive Quality	

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	management and delegated services oversight. The EQIC also reviews and makes recommendations on QI studies, surveys, indicators, interventions, progress in meeting goals and follow-up to findings. The Vice President of Medical Affairs (Medical Director) is the senior executive responsible for the Quality Improvement Program as per the QI program Strategy. The Regional Vice President of Quality Improvement provides direction on activities of the Quality Improvement Department. The Regional Director/Manager of Quality directs the operational components of the QI Program.		Improvement Committee. The EQIC reports to the Board of Directors, is chaired by the Chief Executive Officer and includes members of senior leadership. The EQIC implements, monitors and evaluates the effect of quality improvement policies, procedures and programs; quality of care and services; credentialing; utilization management and delegated services oversight. The EQIC also reviews and makes recommendations on QI studies, surveys, indicators, interventions, progress in meeting goals and follow-up to findings. The Vice President of Quality Improvement (Medical Director) is the senior executive responsible for the Quality Improvement Program according to the QI program description. The Regional Vice President of Quality Improvement provides direction on activities of the Quality	

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			Improvement Department. The Regional Director/Manager of Quality directs the operational components of the QI Program.	
review of written reports from the designated entity on a periodic basis, which shall include a description of QAPI activities, progress on objectives, and improvements made;	Full - The EQIC Description, Committees and Org Chart document provided by the plan notes that the EQIC reviews the QI Program Description, Work Plan and updates, and Annual Evaluation, and is responsible for monitoring delegated services and activities of other committees. As noted above, the Board of Directors annually reviews the Program Description, Work Plan and Program Evaluation, as described in the QI Program Strategy, and the EQIC reports to the Board of Directors as per the QI Program Strategy. The EQIC reviewed and approved the 2012 Quality Improvement Work Plan, Quality Improvement Program Strategy and the 2011 QI Program Evaluation on 7/25/12 as per meeting minutes. The plan also provided EQIC meeting minutes for March, June, July, August and September 2012 for review. The 9/27 EQIC minutes indicates that the EQIC will receive biannual reports from each committee and that programs not meeting goals will be discussed in committee. The plan provided a detailed schedule of reports due from the QM/UM Committee and Service Advisory Committee. The agenda for the 11/2012 EQIC meeting notes that the EQIC will review grievances and appeals, however minutes were not provided for this meeting. The EQIC also reviewed and approved PIP proposals on 8/29/12.	Full	The EQIC Description, committee descriptions, and Organizational Chart provided by CCKY show that the EQIC reviews the QI Program Description, QI Work Plan and updates, and the Annual QI Evaluation, and is responsible for monitoring delegated services and the activities of sub-committees. CCKY also provided quarterly committee reports and monthly EQIC meeting minutes for review. The Board of Directors reviews the QI Program Description, QI Work Plan and Annual QI Evaluation annually. The QI Program Strategy indicates that the EQIC reports to the Board of Directors. The EQIC approved the QI Program Description and QI Work Plan on 5/22/13 as reflected in committee minutes and the QI	

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			Work Plan. CCKY report on 4/30/13 showed EQIC will receive biannual reports from each committee and that programs not meeting goals will be discussed in committee. There is documentation that the EQIC oversaw all audits, surveys, corrective action plans, NCQA accreditation preparation, QI initiatives/studies, and required QI reports and summaries.	
review on an annual basis of the QAPI program; and	Full - As per the QI Program Strategy, the EQIC reviews and approves the QAPI program evaluation. The minutes of 7/25/12 reflect approval of the 2011 QI Annual Review by the EQIC. The EQIC also reviews the program strategy and Work Plan as documented in committee minutes.	Full	CCKY provided the 2012 Annual QI Evaluation report. Quarterly reports and meeting minutes show that EQIC reviewed and approved the 2012 Annual Evaluation, QI program description and QI Work Plan.	
modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization.	Substantial - As noted in the QI Program Strategy, the EQIC reviews quality improvement studies, surveys, indicators and intervention and makes program recommendations based on findings. The QI Work Plan reports 17 submitted quarterly include activities and interventions based on findings of monitoring activities. Areas addressed include customer service call metrics, access, high level complaints and grievances and sentinel/adverse events. Other activities are noted for EPSDT and other quality indicators	Full	The 2012 Annual QI Evaluation highlights opportunities for improvement and action plans for monitored topics within the QAPI program. The 2013 Work Plan is organized by rationale for selection, including accreditation	

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	in quarterly reports. Since there was little to report in the 2011 annual program evaluation due to the short timeframe of member enrollment, the 2012 Program Strategy had little to incorporate from the annual program evaluation. HEDIS and Healthy Kentuckian indicators have not yet been reported. Some areas of concern such as Health Risk Assessment completion, access issues in some regions of the state, and EPSDT screening rates did not have corresponding activities noted in documents provided. Some activities reported onsite, though not yet included in the Work Plan, include addressing access by mapping and increasing urgent care centers and identifying providers who would take members out of panel; formation of a work group regarding Health Risk Assessments; development of EPSDT report cards for providers and an EPSDT training module; and providing feedback to providers on a medical record audit. Some of these activities are documented in committee minutes and others occurred after the review period. **Recommendation for Coventry Cares** The plan should ensure these activities are included in future Work Plans.		requirement, contract requirement, or EQRO review findings. The QI Work Plan now includes a column for comments where descriptive updates are provided. Additionally, committee meeting minutes provide detailed information. For the prior review, IPRO recommended that, in the future, CCKY should ensure these all areas of concern and the activities are included in the QI Work Plan. For the current review, although EPSDT initiatives were not included in the QI Work Plan, CCKY indicated that there is a dedicated work plan for EPSDT. **Recommendation for CCKY** CCKY should consider referencing the EPSDT work plan in the QI Work Plan or including as an attachment.	
The Contractor shall have in place an organizational Quality Improvement Committee that shall be responsible	Full - As per the QI Program Strategy and EQIC Description, Subcommittee and Org Chart document, and as noted above, the Board has delegated oversight of the plan's QI	Full	The QI Program Description states the Board of Directors of Coventry Health and Life Insurance	

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for all aspects of the QAPI program.	program to the Executive Quality Improvement Committee (EQIC). The EQIC implements, monitors and evaluates the effect of quality improvement policies, procedures and programs; quality of care and services; credentialing; utilization management and delegated services oversight. The EQIC also reviews and makes recommendations on QI studies, surveys, indicators, interventions, progress in meeting goals and follow-up to findings. All quality improvement activities and subcommittee recommendations are reported to the EQIC for assessment, development, implementation and monitoring of activities. Several subcommittees are identified in the QI Program Strategy, including the Quality Management/Utilization Management, Service Advisory, Compliance, Credentialing, Quality and Member Access, and Pharmacy and Therapeutics Committees; these committees routinely report to the EQIC. The EQIC Description, Subcommittee and Org Chart document and EQIC meeting minutes document that the EQIC monitors all aspects of the QAPI Program. As per the Program Strategy, the Quality Management/Utilization Management Committee (QM/UM) is the committee that provides clinical input and physician review of QI and UM programs and provides recommendations for the programs to the EQIC. The Vice President of Medical Affairs chairs the QM/UM committee. Minutes reflect clinical review of the QI and UM programs.		Company is ultimately responsible for oversight of the QI Program of CCKY. The BOD delegates oversight of the Quality Improvement and Management program to the Executive Quality Improvement Committee (EQIC). The EQIC reports to the Board of Directors, is chaired by the Chief Executive Officer, and includes members of senior leadership. The EQIC implements, monitors and evaluates quality improvement initiatives and programs; quality of care and services; credentialing; utilization management and delegated services oversight. The EQIC also reviews and makes recommendations on QI studies, surveys, indicators, interventions, progress in meeting goals and follow-up to findings. The Vice President of Quality Improvement (Medical Director) is the senior executive responsible for the Quality	

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			Improvement Program. The Regional Vice President of Quality Improvement provides direction for the activities of the Quality Improvement Department. The Regional Director/Manager of Quality directs the operational components of the QI Program. The Program Strategy indicates that the Quality Management/Utilization Management Committee (QM/UM) provides clinical input and physician review of QI and UM programs and makes recommendations to the EQIC. The Vice President of Medical Affairs chairs the QM/UM committee. Committee meeting minutes reflect clinical review of the QI and UM programs.	
The committee structure shall be interdisciplinary and be made up of both providers and administrative staff. It should include a variety of medical disciplines, health professions and individual(s) with	Full - As per the QI Program Strategy, and as reflected in minutes, the EQIC is comprised of senior leadership staff across departments who are involved in QI Program activities, such as the VP of Medical Affairs, Health Services, Compliance, Pharmacy, Community Development, Provider Relations, Network Operations,	Full	The quarterly reports, and committee meeting minutes demonstrate that the EQIC is comprised of senior leadership staff across the organization participate in QI Program	

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specialized knowledge and experience with Individuals with Special Health Care Needs.	Behavioral Health, Quality and Appeals. Participation across departments is evident in committee minutes. The QM/UM Committee is the subcommittee of the EQIC that includes physician representation; in addition to two plan medical directors, three network providers and MHNet are represented on the committee. QM/UM minutes identify membership from internal medicine and pediatrics as well as behavioral health and hospital representation. Onsite staff noted that representation from obstetrics/gynecology was still being recruited. Network provider input was evident in committee minutes. The QM/UM committee had its inaugural meeting September 20, 2012 and met monthly thereafter in 2012. **Recommendation for Coventry Cares** The plan should continue attempts to recruit an obstetrics representative.		activities. These include the VP of Medical Affairs and the Health Services, Compliance, Pharmacy, Community Development, Provider Relations, Network Operations, Behavioral Health, Quality and Appeals departments. Participation across the organization is evident in committee meeting minutes. The QM/UM Committee is a subcommittee of the EQIC that includes physician representation. The CCKY medical directors, three network providers and MHNet are represented on the committee. QM/UM minutes identify membership from internal medicine and pediatrics as well as behavioral health and hospital representation. In the prior review, IPRO found that CCKY was still seeking OB/GYN provider(s) to participate in the committee. For the current review, CCKY still had not located an OB/GYN to join the committee.	

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			Onsite staff indicated that potential participants were being sought from Partners in Women's Health in Louisville and the Department of OB/GYN at UK in Lexington.	
The committee shall meet on a regular basis and activities of the committee must be documented; all committee minutes and reports shall be available to the Department upon request.	Full - The plan provided agendas and minutes for EQIC meetings from March 28, June 13, July 25, August 29 and September 5, and September 27 of 2012. An agenda was provided for November 14, 2012, although meeting minutes were not. The QM/UM committee met initially on September 20, 2012 and monthly thereafter in 2012; meeting minutes were provided for QM/UM meetings on September, October, November and December of 2012.	Full	CCKY provided monthly committee meeting minutes for the EQIC and QMUM committees. These were included in the quarterly reports. The activities of the EQIC were documented in the comments area of the QI Work Plan.	
QAPI activities of Providers and Subcontractors, if separate from the Contractor's QAPI activities, shall be integrated into the overall QAPI program. Requirements to participate in QAPI activities, including submission of complete Encounter Records, are incorporated into all Provider and Subcontractor contracts and employment agreements. The Contractor's QAPI program shall provide feedback to the Providers and Subcontractors regarding integration of, operation of, and corrective actions necessary	Full - Reports of QI activities relevant to providers are reported to the EQIC annually or more frequently as per the EQIC Description, Subcommittees and Org Chart, and the EQIC is responsible for integration these activities related to providers as well delegation oversight. Minutes of the QM/UM Committee include multiple examples of QI activities relevant to providers and subcontractors, such as clinical guideline dissemination, evaluation of dental decay data, medical record audit for BMI and advanced directive documentation, creation of EPSDT toolkits and audit forms, MHNet training materials and plans for hospital site visits to discuss criteria for utilization reports. The Provider Manual includes requirements for provider agreement to participate in quality improvement activities s including site visits and medical record audits and encounter record	Full	As seen in the EQIC Description, provider and subcontractor QI activities are reported to the EQIC annually or more often. The EQIC is responsible for integration of activities related to providers as well delegation oversight. Minutes of the QM/UM Committee include multiple examples of QI activities relevant to providers and subcontractors, such as clinical guideline dissemination, disease management programs,	

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in Provider and Subcontractor QAPI activities.	submission. These are included in the Provider Manual for delegated services as well. As documented in the QI Program Strategy, the Compliance Committee oversees subcontractor relationships and also oversees the Delegation Oversight Committee. The first meeting of the Delegation Oversight Committee occurred on 9/27/12 as per EQIC minutes, and this committee reports to the EQIC. Minutes for this committee meeting were not provided. Behavioral health has its own quality program, but appears well integrated with physical health as described above. Quarterly report 15 in the second quarter documents feedback to the dental, behavioral health and pharmacy subcontractors regarding compliance and grievances and appeals. As per the encounter data questionnaire submitted to the EQRO, Coventry conducts audit and validation of provider claims. Evidence of feedback to providers was provided in QM/UM minutes (medical record audits).		prescription policies, creation of EPSDT toolkits and audit forms, peer review, provider survey results, authorizations/denials, professional organization recommended guidelines, PIPs, HRA reports, HEDIS results and benchmarks, QOC reports, Medical record review audits, MHNet collaborations, and plans for hospital site visits to discuss criteria for utilization reports. The Provider Manual includes requirements for provider agreement to participate in quality improvement activities including site visits and medical record audits and encounter record submission. These are included in the Provider Manual for delegated services as well. As documented in the quarterly CCKY reports, the Compliance Committee oversees subcontractor relationships. The Delegation Oversight Committee reports to EQIC and monitors the performance of subcontractors.	

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			Behavioral health has its own quality program, but appears well integrated with physical health as described above.	
The Contractor shall integrate other management activities such as Utilization Management, Risk Management, Member Services, Grievances and Appeals, Provider Credentialing, and Provider Services in its QAPI program.	Full - The plan's QI Work Plan, QI Program Strategy and UM Program Description include Utilization Management, Risk Management, Member Services, and Grievances and Appeals in QI activities. Provider Credentialing is incorporated into QI activities relative to quality of care concerns and adverse event monitoring. Provider Services is part of QI activities outlined in the QI Work Plan. Evidence of inclusion of these management activities is also present in EQIC minutes and member lists.	Full	CCKY's QI Work Plan, QI Program Description and UM Program Description include Utilization Management, Risk Management, Member Services, and Grievances and Appeals in QI activities. As of November 1, 2013, under Aetna, the CCKY Credentialing Committee was retired and Aetna National Quality Management and Measurement Department assumed responsibility. CCKY will continue local management of the issues list, contracting and other provider relations functions and delegation oversight agreements in the Network Management Department. Delegation auditing will be shared between CCKY and Aetna. However, provider quality of care issues and overall performance will be incorporated in re-credentialing. Since the MCO is new, no providers have gone	

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			through re-credentialing. CCKY continues its transition to Aetna national processes and will be fully integrated in 2015.	
Qualifications, staffing levels and available resources must be sufficient to meet the goals and objectives of the QAPI program and related QAPI activities. Such activities include, but are not limited to, monitoring and evaluation of Member's care and services, including those with special health care needs, use of preventive services, coordination of behavioral and physical health care needs, monitoring and providing feedback on provider performance, involving members in QAPI initiatives and conducting performance improvement projects. Written documentation listing staffing resources, including total FTE's, percentage of time, experience, and roles shall be submitted to the Department upon request.	Full - The local MCO QI team is noted in the QI Program Strategy to include the Vice President of Medical Affairs, plan medical directors, the Manager of Quality Improvement, four QI Coordinators and one QI Analyst. Case Management, Medical Management and Member Appeals staff also participates in QAPI activities. The Regional VP of Quality Improvement for the Medicaid Region (Kentucky, Michigan and Missouri) is active in EQIC meetings, and as per EQIC minutes oversees the Kentucky Quality Improvement management team. During onsite discussion in October, the plan identified an EPSDT Case Manager as a key vacancy; this position has now been filled as per onsite staff during the compliance review. The Behavioral Health Director and Medical Director and behavioral health care advocates are co-located at the health plan. The health plan staff includes a social worker behavioral health-physical health liaison. The plan has onsite hospital concurrent reviewers. Corporate plan resources include Medical Directors, Corporate VP of Quality, QI Managers, IS support and Member Services as per the QI Program Strategy. Regional resources include the Vice President of QI, Director of Quality and HEDIS Manager.	Full	At the corporate level, the Board of Directors and the Board of Managers delegates responsibility for the quality improvement process to the Corporate Quality Improvement Committee (CQIC). CCKY's Chief Medical Officer (CMO) has overall responsibility for the Corporate QI Program. The corporate Medical Director is the designated physician for the QI Program, has oversight of the program and is an active member of the CQIC. The Corporate Vice President of QI leads the activities in the QI Department. The Corporate Sr. Vice President and other Corporate QI staff participate in the QI Program. At the regional level, the Regional Quality Vice President and Regional QI Coach/Chief Executive Officer have overall responsibility	

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	Coventry Cares meets actively with corporate staff. Monitoring and evaluation is effectively implemented as described below.		for the Regional QI Program. The Regional QI Vice President reports directly to the Regional QI Coach. The Regional Quality Improvement Director manages the day-to-day activities of the QI Program and reports directly to the Regional Vice President of Quality Improvement. Regional QI Department Staff are responsible for implementation, analysis and reporting on QI activities. Health Plan Senior Medical Directors participate in the Regional Quality Improvement Committee. Locally, the CMO and VP of Medical Affairs are responsible for directing the QI programs. Medical Directors are responsible for medical management programs. The Director of Health Services ensures staffing levels and staff competencies. Managers and supervisors oversee day-to-day activities. QI Program staff includes clinical and professional staff supported by Medical Directors and staff from the following departments: UM and	

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			QI, Network Management, Provider Relations, Compliance, IT support and Member Services. Analytic Resources encompass multiple experienced QI personnel, data analysts, certified coders, Information Systems and actuarial experts. Behavioral health QI activities are integrated into the QI program with a doctorate-level behavioral health practitioner serving as a member of the Corporate QI Committee and the Regional Physician Advisory Committee. The EQIC committee is comprised of a multidisciplinary membership, including: Medical Directors, BH, pharmacy, Network Management, Service Operations, and Health Services Directors, and Managers of Appeals, Compliance, and Provider relations. This structure will likely change for 2015 as CCKY becomes more integrated into the Aetna model.	

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19.4 QAPI Monitoring and Evaluation				
A. The Contractor, through the QAPI program, shall monitor and evaluate the quality of clinical care on an ongoing basis. Health care needs such as acute or chronic physical or behavioral conditions, high volume, and high risk, special needs populations, preventive care, and behavioral health shall be studied and prioritized for performance measurement, performance improvement and/or development of practice guidelines. Standardized quality indicators shall be used to assess improvement, assure achievement of at least minimum performance levels, monitor adherence to guidelines and identify patterns of over- and under-utilization. The measurement of quality indicators selected by the Contractor must be supported by valid data collection and analysis methods and shall be used to improve clinical care and services.	Full - The Annual Program Evaluation, quarterly reports and committee minutes provide evidence of ongoing monitoring of quality of care. Enrollment in Disease Management and Case Management is monitored, and gaps in care for members with chronic conditions or missing services are monitored by the plan as per quarterly reports. Relevant HEDIS measures will also be monitored for these members. The plan is monitoring substance abuse among pregnant women and antidepressant medication management. The plan has begun monitoring monthly administrative HEDIS rates, as per plan staff onsite, although reports were not available for review. The plan monitors Geo Access, EPSDT screens, Health Risk Assessment completion, utilization data and member complaints and grievances. The plan conducted an audit of provider documentation of BMI and Advance Directives. Activities have been implemented relative to the findings. The plan is to begin provider appointment availability secret shopper calls in 2013. The plan will begin to implement a Key Performance Indicator log to establish baseline data, which will be reviewed by the EQIC. Indicators for this log include Customer Service and Language line Access, Member and Provider Grievances and Appeals, Network Additions and Credentialing, Authorizations, Utilization – bed days, average length of stay, readmission rates, high volume	Full	The 2012 Annual Evaluation and quarterly reports provide evidence of ongoing monitoring of quality of care. The 2012 Annual Evaluation describes monitoring activities and results focused on special needs, acute or chronic physical or behavioral conditions, high volume, and high risk populations, in the population analysis. The population analysis highlights opportunities for improvement and action plans. The QMUM committee minutes show evidence of development of practice guidelines, development of performance improvement goals and case management initiatives, oversight of PIPs, utilization reports, grievances and appeals, and nurse line protocols and reports. There is evidence of monitoring of quality of care concerns and sentinel events in committee minutes.	

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	diagnosis, Utilization by place of service, ER Utilization, Case Management access and case intensity levels, Outreach initiatives, Disease Management enrollment by disease category, Adverse Events and Quality of Care concerns. The plan's P/P QI-009 outlines monitoring, investigation and trending of adverse events from a variety of sources, and the QI Work Plan documents that adverse events and potential quality of care concerns are tracked, trended and reported annually. There is evidence of monitoring of quality of care concerns and sentinel events in committee minutes. Committee minutes for the EQIC indicate that improvement of coding of quality of care concerns is being worked on to improve trending ability, since currently it is difficult to identify trends. Quarterly reports also indicate that appeal overturn rates are monitored and as per committee minutes, the top ten appeals will be evaluated. CAHPS member survey will be conducted in 2013. The plan has analyzed member demographic data and diagnosis prevalence to prioritize quality improvement activities and focus disease management programs as per the QI Program Evaluation. The QI Work Plan includes monthly monitoring of customer service and pharmacy call metrics (abandonment, speed of answer), nurse line calls, and utilization management calls (prior authorization), and these appear to be actively monitored.		The 2012 Annual Evaluation documents that adverse events and potential quality of care concerns are tracked, trended, and reported annually. The plan has analyzed member demographic data and diagnosis prevalence to prioritize quality improvement activities and focus disease management programs as per the 2012 Annual Evaluation. The QI Work Plan includes monthly monitoring of customer service and pharmacy call metrics (abandonment, speed of answer), nurse line calls, and utilization management calls (prior authorization), and these appear to be actively monitored. The plan coordinates improvement initiatives with MHNet, such as PIPs covering Major Depression, ED Utilization, and hospital readmissions. Other BH collaborations include prevention program focused on ADHD, Anxiety, Depression in the	

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	As per MCO quarterly report 18, behavioral health network provider: enrollee ratios and service utilization are being tracked. The plan is working on clarification for some behavioral health metrics. **Recommendation for Coventry Cares** The plan should continue work on improving trending of quality of care concerns by improving categorization and monitoring detailed types of concerns.		Older Adult, and post partum depression. In 2012, CCKY conducted a review of medical record keeping practices. Two indicators did not achieve the goal of 80% compliance: documenting BMI and Advance Medical Directives. CCKY implemented interventions and the follow-up review was conducted. In 2013, CCKY reported its first HEDIS and CAHPS rates. On site, CCKY provided a summary of the HEDIS measures to be targeted. In the prior review, IPRO recommended that CCKY should continue work on improving trending of quality of care concerns by improving categorization and monitoring detailed types of concerns. The 2012 QI Evaluation indicated that CCKY improved its processes for Adverse Events (AE) and Quality of	

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			Care (QOC) issues. P/P and training improved the MCO's ability to effectively refer, categorize, review and analyze AEs and QOCs. As a result, CCKY identified that post-up infections were an issue. CCKY conducted a focused study and implemented an improvement plan.	
B. Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee.	Full - Clinical and preventive guidelines are included in the EQIC Description and QI Program Strategy. EQIC and QM/UM committee minutes include discussion of clinical guidelines. The plan presented USPSTF Preventive Health Guidelines to the EQIC on June 13, and behavioral guidelines were reviewed by the EQIC on 8/29/12. The QM/UM committee discussed disease management guidelines, notification of providers regarding these guidelines and ADHD guidelines as per committee minutes. The QM/UM committee at the 9/20 meeting conducted peer review, and quality of care concerns and adverse events are investigated and evaluated by the plan Medical Director. The plan has conducted a medical record audit of BMI documentation and Advance Directives, and began monthly monitoring of HEDIS measures, which will be reported in June 2013. Provider compliance with guidelines monitoring will include monitoring of HEDIS measures as per the QI Program Evaluation.	Full	Clinical and preventive guidelines are included in the QI Program Description, EQIC and QM/UM committee minutes. QMUM meeting minutes from July 18, 2013 indicate a review of Behavioral Health Guidelines. Meeting minutes from April 18, 2013 indicate review and edit of Short-Term Chronic Opiate policy, AAP or ADA Dental Health Screenings, and review of CDC changes to immunization schedules; May 16,2013 shows approval of the "Preventive Health Guide Lines"; December 19, 2013 indicates review of Clinical Policy Updates. Policy updates and clinical	

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			guidelines are posted on the online provider portal: directprovider.com. Updates are also communicated through newsletters as evidenced in Provider Newsletter volume 1 issue 2. Quarterly report 1/30/14 indicates that an annual medical record audit was performed and improvement efforts were implemented for documentation of BMI and Advance Directives. Additionally, CCKY reported its first HEDIS rates in 2013. HEDIS is used to evaluate provider compliance with selected guidelines.	
Areas identified for improvement shall be tracked and corrective actions taken as indicated.	Full - A medical record chart audit was conducted for BMI and Advance Directive documentation, with feedback given to providers. HEDIS measures, which will be used to assess provider compliance with guidelines, have not yet been reported. However, as per quarterly report 18, providers are being informed of members with gaps in services based on monthly monitoring of selected HEDIS measures. As per QM/UM minutes, providers with referrals for Quality of Care concerns or adverse events are being tracked and trended. The plan identified that customer service calls did not meet goals, and actions and	Full	As indicated above, CCKY conducted interventions related to documentation of BMI and Advance Directives with a 6-month follow-up review. HEDIS measures were first reported in 2013 and onsite, CCKY provided documentation regarding the HEDIS measures that will be targeted for improvement (noted	

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	interventions planned were outlined in the activity summary of the Work Plan in quarterly reports. The plan indicated that EPSDT report cards for providers were being developed, and QM/UM Committee minutes indicate that an EPSDT audit form is being developed. EPSDT rates were noted to be below goal, and the plan implemented automated calls and mailings to address the low screening rates. A Health Risk Assessment (HRA) work group has been formed to address HRA completion. Areas with opportunity for improvement are noted in the Annual QI Evaluation, with associated improvement activities.		previously in this report). Gap reports posted to directprovider.com inform providers of members with gaps in services based on monthly monitoring of selected HEDIS measures and ED utilization has been added. Additionally, CCKY met with Aetna corporate regarding provider profiling initiatives and High Performance Networks (based on providers/groups that exceed goals). As per QM/UM minutes, providers with referrals for AEs/QOCs are being tracked and trended, and a focused study with subsequent interventions was completed. Regarding the HRA completion rate, please see the QAPI Structure and Operations Tool. Areas with opportunity for improvement are noted in the 2012 Annual Evaluation, with associated improvement activities. The Work Plan documents tracking	

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			of various improvement activities.	
The effectiveness of corrective actions must be monitored until problem resolution occurs. The Contractor shall perform reevaluations to assure that improvement is sustained.	Full - Effectiveness of interventions is monitored by ongoing tracking of indicators and provider quality referrals as noted above and as described in quarterly reports. There were no distinct provider-related corrective actions that appeared to be identified and monitored by the plan in the submitted documentation or discussion.	Full	EQIC meeting minutes on September 25, 2013 indicate corrective action plan was developed for a vendor as the result of findings on the delegation oversight summary report. Tracking of indicators via monthly HEDIS, PIPs, and performance measures among others is used to evaluate to assess the effectiveness of corrective actions and interventions. The QI Program Description and the 2012 Annual Evaluation state that the Delegation Oversight Committee develops corrective action plans and monitors improvements. MHNet maintains its own Corrective Action Plans.	
C. The Contractor shall use appropriate multidisciplinary teams to analyze and address data or systems issues.	Full - The plan's EQIC membership is multidisciplinary and includes senior leadership from Quality Improvement, Provider Relations, Pharmacy, Health Services, Behavioral Health, Operations, Government Relations, the Medical Director, and others, including corporate staff. The QM/UM committee, which reviews and analyzes clinical data, includes pediatric, internal medicine, hospital and	Full	The plan's EQIC membership is multidisciplinary and includes senior leadership from Quality Improvement, Provider Relations, Pharmacy, Health Services, Behavioral Health, Operations, Government Relations, the	

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	behavioral health members, as well as Case Management, Appeals, Health Services and Pharmacy representation. The plan is engaging all departments as it plans for HEDIS reporting. As per the QI Program Strategy, there is computer/data and clinical/professional staff at the local plan level and also at the corporate level to augment local staff for QI activities as per the QI Program Strategy. The behavioral health PIP is being conducted by a team that includes both MHNet and plan staff.		Medical Director, and others, including corporate staff. The QM/UM committee, which reviews and analyzes clinical data, includes pediatric, internal medicine, hospital and behavioral health members, as well as Case Management, Appeals, Health Services and Pharmacy representation. According to the QI Program Description, there is computer/data and clinical/professional staff at the local plan level and also at the corporate level to augment local staff for QI activities as per the QI Program Description. The behavioral health QI activities include collaboration between MHNet and plan staff.	
D. The Contractor shall submit to the Department upon request documentation regarding quality and performance improvement (QAPI) projects/performance improvement projects (PIPs) and	Full - At the time of the review, the plan had submitted quarterly MCO reports through January 2013 and two PIP topics, one behavioral health focused (Major Depression) and one physical health focused (Emergency Department Utilization). PIP activities are reported in quarterly reports number 19. PIP revisions as per EQR and DMS	Full	According to the QI Work Plan, the 2013 QI Program Description and annual UM Program Evaluation were submitted to DMS in July 2013. Updates to the QI Program were sent to DMS on a quarterly	

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assessment that relates to enrolled members.	recommendations were submitted by the plan.		basis. CCKY PIP topics include: (2103) Major Depression and ED Utilization and (2014) ADHD and Inpatient Readmissions. PIP proposals were revised and submitted based upon EQRO recommendations. 2013 PIPs were approved by DMS on 2/24/2014 and 2014 PIPs were approved by DMS on 3/4/2014.	
E. The Contractor shall develop or adopt practice guidelines that are disseminated to Providers and to Members upon request.	Substantial - As per the QI Program Strategy, the plan's evaluation of the QAPI Program includes evaluation of utilization and clinical performance data against evidence based practice. The Provider Manual describes clinical guidelines and where to locate them on the plan's website. The process for development, approval and distribution of review guidelines was described in the first quarterly reports #23, Evidence Based Guidelines for Practitioners. The plan did not provide a specific policy relevant to the development or adoption of clinical practice guidelines. Clinical review guidelines are included in the UM Program Description, which notes that they are available on request and are disseminated on the provider website, provider manual and provider newsletters.	Substantial	According to the QI Program Description, CCKY's evaluation of the QAPI Program includes evaluation of utilization and clinical performance data against evidence based practice. The Provider Manual describes clinical guidelines and where to locate them on the plan's website. Guidelines are provided to members in the Member Handbook including EPSDT guidelines, routine testing/screening and cancer	As a part of the CoventryCares and Aetna migration, CCKY will adopt the Aetna policy and procedures outlining development, adoption and dissemination of clinical practice guidelines.

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	Committee minutes provide evidence of discussion of clinical practice guidelines. EQIC minutes of 7/25 include a report on an annual review of preventive health guidelines by the corporate Quality Team, and note that these guidelines are distributed to plans. The QI Work Plan includes annual review of clinical practice guidelines by the QM/UM Committee with recommendations to EQIC. Per the Work Plan, this review was completed by the EQIC in June of 2012, although the QM/UM Committee first met 9/20/12. QM/UM Committee minutes of 9/20 reflect discussion of Disease Management guidelines and planned voting on the guidelines by members; per the Work Plan these were distributed to providers on 9/30/12. ADHD guidelines were also discussed by the QM/UM. Preventive Health Guidelines are documented in the QI Work Plan as approved by the EQIC 6/27/12 and distributed to providers on 9/30/12. Per the QI Work Plan, the immunization schedule is also annually reviewed and distributed to PCPs and posted in the member and provider handbook. An updated immunization schedule adopted by EQIC on 8/29/12 was noted to be disseminated via provider website and provider notification via FAX as per meeting minutes. MHNet reviews behavioral health guidelines annually; these were approved by the EQIC on 8/29. **Recommendation for Coventry Cares** The plan should consider developing policies/procedures for development, adoption and dissemination of clinical		screenings. The member newsletters also include guidelines. QMUM meeting minutes note review of evidence based clinical guidelines and standards and the committee's input and oversight of disease management guides. These guides refer to guidelines established by professional entities and are available to providers on the website portal. Clinical review guidelines are included in the UM Program Description, which notes that they are available on request and are disseminated on the provider website, provider manual and provider newsletters. In the prior review, IPRO recommended that CCKY consider developing policies/procedures for development, adoption and dissemination of clinical practice guidelines. CCKY indicated that this is on hold due to the Aetna merger, which was announced October 2012 and was completed	

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	practice guidelines.		in May 2013, with full integration of CCKY's processes by Q1 2015. **Recommendation for CCKY** The plan should consider developing policies/procedures for development, adoption and dissemination of clinical practice guidelines.	
The guidelines shall be based on valid and reliable medical evidence or consensus of health professionals;	Full - The Provider Manual describes the adoption of nationally recognized guidelines by the plan and sources such as the American Academy of Pediatrics. The plan references USPSTF preventive health guidelines and behavioral health guidelines adopted from the American Psychiatric Association (APA) in committee minutes and quarterly reports. USPSTF preventive health guidelines were presented to the EQIC June 13, 2012. The UM Program Description documents the use of InterQual guidelines for clinical decision-making. This document also indicates that medical necessity is determined based on scientifically based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are accepted by Coventry. An updated immunization schedule was approved by EQIC on 8/29/12.	Full	Disease Management Guides site clinical evidence-based standards as recommended by nationally recognized professional organizations, such as the American Lung Association, National Heart Lung and Blood Institute, American Heart Association, and American College of Cardiology Foundation. QMUM Meeting minutes indicate that the CDC was used as a resource to review immunization updates and the American Academy of Pediatrics and the American Dental Association Dental Screening was reviewed.	
consider the needs of Members;	Full - The UM Program Description notes that guidelines used in UM decision-making may be modified to consider	Full	Quarterly reports state the purpose of QMAC subcommittee	

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	an individual member's characteristics. EQIC minutes of 7/25 document updated Corporate Quality Team recommendations for dyslipidemia screening in children, dental education, gonorrhea screening, iron deficiency anemia screening, screening for hearing loss and tuberculosis testing. These guidelines are relevant to plan Medicaid membership. QM/UM Committee minutes include discussion of clinical guidelines such as ADHD, which are based on members' needs. Disease Management programs, which have associated guidelines, were prioritized according to prevalence of conditions among plan membership.		meetings is to interact with members and get their feedback on topics such as quality of care, marketing materials, customer service, network access, benefit interpretation, and other areas that may affect the Plan. These meetings were held quarterly in four regions. A total of 16 meetings were scheduled for 2013. Representatives from community organizations are present at the meetings to advocate for the needs of members. The EQIC reviewed QMAC reports bi-annually. As per QMAC meeting minutes, there is an exchange of information between the community advocates and the plan about heath tips, promotional activities and community events. Also included in the meeting minutes is discussion of concerns about cultural norms and small numbers of providers affecting access to dental care.	

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			The 2012 Annual Evaluation described results of population analysis. This analysis performs a breakdown of member demographics, top 25 diagnoses, special needs categories, linguistic assistance, and cultural competencies. Customer service is also analyzed to direct improvements. In 2013, the plan performed the CAHPS survey to assess member satisfaction. The results were used to identify opportunities of improvement according to the CAPHS report and review by EQIC and the Service Advisory Committee (SAC). As per quarterly reports, the SAC oversees evaluation and improvement efforts related to member and provider satisfaction, access, availability, and quality of service.	
developed or adopted in consultation with contracting health professionals, and	Full - The QI Program Strategy indicates that the QM/UM committee, which includes contracting health professionals, will review guidelines. The QM/UM meeting minutes include discussion clinical guidelines. Preventive health guidelines were approved by EQIC prior to the initial QM/UM meeting. MHNet reviews behavioral Health	Full	The QI Program Description indicates that the QM/UM committee, which includes contracting health professionals, will review guidelines.	

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	guidelines prior to EQIC approval.		The QM/UM meeting minutes include discussion of clinical guidelines. Preventive health guidelines were approved by QM/UM as per report 7/30/13. MHNet reviews behavioral Health guidelines prior to EQIC approval.	
reviewed and updated periodically.	Substantial - Committee minutes of the EQIC note that clinical practice guidelines are reviewed and updated annually by corporate Quality; local plan policy on guidelines review and adoption was not provided. The QM/UM minutes note that disease management guidelines are updated annually. EQIC minutes of 7/25 and 8/29 note updated preventive guideline recommendations and immunization schedules. **Recommendation for Coventry Cares** The plan should consider policies/procedures regarding development, adoption, dissemination and updating of clinical practice guidelines.	Substantial	The Work Plan indicates that clinical guidelines are reviewed, updated, and approved annually. The case management and health services teams are primarily responsible. The guidelines are also submitted to the QMUM committee for annual review according to QMUM meeting minutes listed in report 130730. In the prior review, IPRO recommended that CCKY consider policies/procedures regarding development, adoption, dissemination and updating of clinical practice guidelines. As noted previously, CCKY is in the process of integrating into Aetna.	As a part of the CoventryCares and Aetna migration, CCKY will adopt the Aetna policy and procedures outlining development, adoption and dissemination of clinical practice guidelines.
Decisions with respect to UM, member education, covered services, and other areas to which	Full - The plan employs InterQual guidelines and other scientifically based guidelines from national medical research, professional medical specialty organizations or	Full	The UM Program Description states that the UM program includes processes to ensure that	

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the practice guidelines apply shall be consistent with the guidelines.	governmental agencies for UM decision making as per the QI Program Strategy, QI Program Evaluation and Provider Manual. National guidelines are also employed for disease management, which includes member education, as per QM/UM 9/20/12 minutes.		approved clinical practices national guidelines such as InterQual are applied equitably throughout the plan's provider network. UM evaluates medical necessity based upon evidence based medical guidelines and assures that providers are educated on current clinical criteria. The QMUM Committee reviews and approves clinical practice guidelines, preventive health guidelines, and the disease management program. The disease management guides reflect educational outreach to members including mailings, telephonic outreach, access to community resources, and web-based education. The provider manual indicates that medical necessity determinations are made based on McKesson's InterQual® criteria, which is a nationally-recognized evidenced-based product. Copies of criteria used in making medical necessity determinations may be obtained	

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			online at www.directprovider.com, by phone or by requesting a hard copy. A Medical Director is available for peer-to-peer discussions. The Member Handbook discusses the UM program.	
19.5 Innovative Programs				
Contractor shall implement its innovative program as presented in the response to the RFP and report quarterly on its program to improve and reform the management of the pharmacy program as contained in the Contractor's response to the RFP.	Minimal - The plan provided information on its Text 4 Baby program. The plan also provided text describing lower levels of behavioral health care including Intensive Outpatient Programming (IOP) and Partial Hospitalization (PHP) to allow members to transition to outpatient care or avoid hospitalization. Reports on the plan's program to improve and reform the pharmacy program management were not provided for review. The plan provided text that use of generic drugs is promoted in the plan's formulary, and has successfully increased generic drug dispensing rates. **MCO Response:** CoventryCares of Kentucky has a Policy (PHM – 002) that provides criteria for the formulary. One of the criterion for a drug to be added – as long as safety and efficacy are comparable – is cost. Drugs that have lost patent protection and are available as generics will be selected under this criteria. Kentucky Pharmacy Law and	Full	As per the QI Program Description, CCKY's Pharmacy Benefit Manager where applicable, uses a Drug Utilization Review (DUR) program, in conjunction with retail pharmacy computer systems, alerts pharmacies of potential drug to drug interactions and adverse effects resulting from the age or gender of a member; or other pharmacy problems at the time a prescription is filled. Additionally, CCKY maintains a local pharmacy and therapeutics (P&T) committee which is responsible for advising the National P & T Committees regarding local and community	

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	claims processing logic mandates that the lowest cost generic be dispensed when a prescription is written for a product that has lost patent protection. These elements combine to drive market share to generics. As proof of the efficacy, market share – as shown in the Pharmacy Monthly Dashboard – for CoventryCares of Kentucky grew from 81.5% in March, 2012 to 86.4% in March, 2013.		needs related to the health plan's pharmacy benefit program(s). The Kentucky P&T Committee is a sub-committee of the EQIC that ensures members receive the maximum value from their pharmacy benefit by continual reinforcement of high quality, cost-effective prescribing habits of CCKY practitioners. Meeting minutes indicate that the QMUM committee reviewed a Chronic Opiate Policy and the Fraud/Waste/Abuse report on Narcotics. A document entitled the "CoventryCares of Kentucky Prior Authorization for Schedule II, III and IV Opiate Containing Medications" was distributed by Medco, the plan's pharmacy vendor, to inform providers of changes to prior authorization requirements for short-acting and long-acting opiates. Regarding CCKY's program to improve and reform the pharmacy program, CCKY provided a spreadsheet containing monthly	

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			data for Suboxone versus generic dispensing. The rates dropped from 97.97% Suboxone/2.03% generic in April 2012 to 0.78% Suboxone/99.22% generic as of January 2013. During the onsite interview, CCKY indicated that this was achieved via use of co-pay tiers, formulary changes, and physician education and that in general, use of generics had increased to ~ 89 – 90%. In 2013, IPRO noted that reports on the plan's program to improve and reform the pharmacy program management were not provided for review. For the current review, CCKY provided more complete information, as described above.	
20.1 Kentucky Outcomes Measures and HEDIS Measures				
The Contractor shall implement steps targeted at improvement for selected performance measures, identified in Appendix O, in either the actual outcomes or processes used to affect those outcomes.	Full - The plan has not yet reported Kentucky outcomes or HEDIS measures. However, the plan has begun activities targeted to these measures as reported in quarterly reports 18 and 17. The plan has also begun monthly monitoring of HEDIS measures and implemented a work group for HEDIS reporting. The QI Work Plan includes	Full	In 2013, CCKY reported its first Healthy Kentuckians Outcomes performance measure rates. The QI Work Plan lists as objectives improving rates on the following indicators: BMI; Nutritional	

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Once performance goals are met, select measures may be retired and new measures, based on CMS guidelines and/or developed collaboratively with the Contractor, may be implemented, if either federal or state priorities change; findings and/or recommendations from the EQRO; or identification of quality concerns; or findings related to calculation and implementation of the measures require amended or different performance measures, the parties agree to amend the previously identified measures.	Healthy Kentuckian performance measures Adult and Child BMI and counseling, cholesterol screening, adolescent screening, prenatal risk assessment and CSHCN as well. EQIC minutes of 6/13/12 indicate that seven measures have been targeted for interventions for improvement, including "childcare" visits, cervical cancer screening, BMI, and prenatal/postpartum. These targeted measures are further discussed in EQIC 8/29 minutes, where it is noted that EPSDT reminders will address well visits, and that 20 providers contributing to these measures will be targeted for intervention. The QI Work Plan also includes monitoring of the HEDIS measures controlling high blood pressure, annual dental visit, well child visits, lead screening and access to PCPs as per "HEDIS timeframes". MHNet is working with PCPs regarding Antidepressant Medication Management. Non-compliant members are being identified for HEDIS measures, and members who are missing services are being identified for providers.		Screening/Counseling; Physical Activity Counseling; Height and Weight for children and adolescents; Cholesterol Screening for Adults; Adolescent Screening/Counseling; Prenatal Risk Assessment Counseling and Education; Children with Special Health Care Needs (CSHCN) (access and preventive care). In 2013, CCKY reported its first HEDIS measure rates. CCKY's HEDIS 2013 Results and Goals indicates that the following measures met the 10th percentile: Comprehensive Diabetes Care - Eye Exam; Controlling High Blood Pressure; Use of Imaging Studies for Low Back Pain; Weight Assessment Counseling – BMI, Nutrition, & Physical Activity; and Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life. The QI Evaluation relates that CCKY has posted gap reports to the provider portal	

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			(directprovider.com); worked collaboratively with MHNet on an initiative to address substance use in pregnancy; sent reminders for post partum visits; and addressed EPSDT services by hiring an EPSDT Case Manager, conducting outreach, sending reminders; working with high volume pediatric practices; and addressing members' transportation problems.	
Additionally, the Department, Contractor, and EQRO will review and evaluate the feasibility and strategy for rotation of measures requiring hybrid or medical record data collection to reduce the burden of measure production. The group may consider the annual HEDIS measure rotation schedule as part of this process.	NA - measures not yet reported	Not Applicable	CCKY reported its first HEDIS data in 2013. On annual basis DMS in collaboration with the EQRO, evaluates the measures required for reporting. The measure set has been revised and refined. MCOs are encouraged to provide input and have done so. To date, no measures have been rotated.	
The Contractor in collaboration with the Department and the EQRO shall develop and initiate a performance measure specific to ISHCN.	NA - the plan was provided with specifications for Individuals with Special Health Care Needs (Children and Adolescents) Access and Preventive Care, but has not yet reported on this measure, provided feedback or worked collaboratively as of yet on measure development.	Full	The ISHCN measures were selected prior to CCKY's participation in Kentucky Medicaid. However, CCKY reported the Healthy Kentuckian Outcomes performance measures for the first time in 2013 as	

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			required.	
The Department shall assess the Contractor's achievement of performance improvement related to the health outcome measures. The Contractor shall be expected to achieve demonstrable and sustained improvement for each measure.	NA - the plan has not yet reported the health outcome measures.	Full	CCKY reported the Healthy Kentuckian Outcomes performance measures for the first time in 2013 as required. Improvement initiatives are in progress. However, Remeasurement to assess improvement will not occur until 2014.	
Specific quantitative performance targets and goals are to be set by the workgroup. The Contractor shall report activities on the performance measures in the QAPI work plan quarterly and shall submit an annual report after collection of performance data. The Contractor shall stratify the data to each measure by the Medicaid eligibility category, race, ethnicity, gender and age to the extent such information has been provided by the Department to the Contractor. This information will be used to determine disparities in health care.	NA - While the workgroup has not yet set performance targets and goals, the QI Work Plan includes a category related to Kentucky performance measures Adult and Child BMI and counseling; cholesterol screening, adolescent screening, prenatal risk assessment and CSHCN. Quarterly report 18 is specific to activities regarding performance measures and report 17 is specific to Work Plan activities updates; these reports were submitted for 2012 on 4/30/12, 7/30/12 and1/30/13. An annual report of performance measure data and demographic stratification was not yet available for review, as they will be reported in 2013.	Full	The Healthy Kentuckians Outcomes measures include performance targets/goals. The QI Program Description addresses both the Kentucky Appendix O measures and HEDIS measures. The QI Work Plan includes monitoring of indicator benchmarks and outcomes; quarterly reporting of QI initiatives; and lists each of the Appendix O performance measures as a task for improvement efforts. An annual report of performance	

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			measure data and demographic stratification will be reported in the 2013 QI Evaluation (pending committee approval). CCKY did submit its HEDIS data stratified with the final audit report and IDSS.	
20.2 HEDIS Performance Measures				
The Contractor shall be required to collect and report HEDIS data annually. After completion of the Contractor's annual HEDIS data collection, reporting and performance measure audit, the Contractor shall submit to the Department the Final Auditor's Report issued by the NCQA certified audit organization and an electronic (preferred) or printed copy of the interactive data submission system tool (formerly the Data Submission tool) by no later than August 31st.	NA - The plan is scheduled to report HEDIS measures for the first time in 2013. The plan indicated during the onsite meeting that monthly administrative HEDIS rates were currently being run and tracked; reports were not provided for review. Preparations for HEDIS reporting include HEDIS meetings and engagement of other plan departments. August 29 EQIC minutes note that the plan is developing a HEDIS culture, with participation of all departments in HEDIS. There is a corporate HEDIS team in place, and the plan staff can access the Navigator system to build on provider HEDIS information. As per the QI Work Plan, HEDIS activities are scheduled for 2013, including a HEDIS audit and reporting.	Full	CCKY reported its first HEDIS data in 2013 and will report HEDIS 2014 in June 2104. The data was audited and CCKY provided the final audit report, IDSS, and stratified measure rates as required.	
In addition, for each measure being reported, the Contractor shall provide trending of the results from all previous years in chart and table format. Where applicable,	NA - measures not yet reported.	Full	CCKY submitted the final audit report, IDSS, and table of HEDIS 2013 rates with percentile ranking and national average and 75th percentile for comparison.	

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benchmark data and performance goals established for the reporting year shall be indicated. The Contractor shall include the values for the denominator and numerator used to calculate the measures.			No trending was possible, as this is the first reporting year. Denominators, numerators, and rates are included in the IDSS. A "HEDIS 2014" report was submitted and included CCKY's HEDIS 2013 results and goals for HEDIS 2014. According to CCKY, HEDIS 2014 goals were chosen using NCQA's HEDIS Benchmark and Goal Setting Methodology.	
For all reportable Effectiveness of Care and Access/Availability of Care measures, the Contractor shall stratify each measure by Medicaid eligibility category, race, ethnicity, gender and age.	NA - measures not yet reported.	Full	CCKY included the stratified Effectiveness of Care (EOC) and Access/Availability (A/A) measure rates in 2 embedded files within the HEDIS report document submitted.	
Annually, the Contractor and the Department will select a subset of targeted performance from the HEDIS reported measures on which the Department will evaluate the Contractor's performance. The Department shall inform the Contractor of its performance on each measure, whether the	NA - measures not yet reported.	Not Applicable	HEDIS 2013 (Measurement Year 2012) was the first year for reporting at the CCKY. To date, DMS has not chosen a subset of measures for evaluation. Annually DMS, in collaboration with the EQRO, evaluates the measures required for reporting.	

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Contractor satisfied the goal established by the Department, and whether the Contractor shall be required to implement a performance improvement initiative. The Contractor shall have sixty (60) days to review and respond to the Department's performance report.				
The Department reserves the right to evaluate the Contractor's performance on targeted measures based on the Contractor's submitted encounter data. The Contractor shall have 60 days to review and respond to findings reported as a result of these activities.	NA - measures not yet reported.	Not Applicable	HEDIS 2013 (Measurement Year 2012) was the first year for reporting by CCKY. To date, DMS has not chosen a subset of measures for evaluation using MCO submitted encounter data.	
20.3 Accreditation of Contractor by National Accrediting Body				
A Contractor which holds current NCQA accreditation status shall submit a copy of its current certificate of accreditation with a copy of the complete accreditation survey report, including scoring of each category, standard, and element levels, and recommendations, as presented via	NA - the plan has not yet undergone the NCQA accreditation process or audit. NCQA accreditation is planned for 2014.	Not Applicable	NCQA accreditation is planned for July 2014. Preparation for the accreditation survey is in progress as seen in the EQIC, QMUM, and QMAC meeting minutes and the QI Work Plan.	

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the NCQA Interactive Survey System (ISS): Status. Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History to the Department in accordance with timelines established by the Department.				
If a Contractor has not earned accreditation of its Medicaid product through the National Committee for Quality Assurance (NCQA) Health Plan, the MCO shall be required to obtain such accreditation within two (2) to four (4) years from the effective date of this contract.	NA - The plan is preparing for NCQA accreditation, and the QI Work Plan notes an anticipated NCQA accreditation as of 2014.	Not Applicable	CCKY is currently pursuing accreditation.	
20.4 Performance Improvement Projects (PIPs)				
The Contractor must ensure that the chosen topic areas for PIPs are not limited to only recurring, easily measured subsets of the health care needs of its Members. The selected PIPs topics must consider: the prevalence of a condition in the enrolled population; the need(s) for a specific service(s); member	Full - The two topics that were submitted 9/1/12 were not accepted by DMS due to lack of focus. The plan ultimately chose Major Depression and ED Utilization as PIP topics. The re-submitted PIP proposals address the relevance of the topics to the plan membership very well, and the topics are challenging to address and were approved by DMS/EQRO. Major Depression is prevalent, and ED utilization is a noted problem area for the plan that may indicate access problems. The plan considered potential	Full	The 2013 PIPs address topics that are issues of state and national concern and areas where CCKY did not meet national benchmarks: Major Depression and ED Utilization. The 2014 PIP topics include Preventing Readmissions and	

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demographic characteristic and health risks; and the interest of Members in the aspect of care/services to be addressed.	disparities in care in the proposal. The PIP topics were approved by the EQIC and the QM/UM committees.		ADHD. CCKY's PIP proposals included strong rationales, with current performance, relevance to the plan membership, potential disparities. The PIP topics were approved by the EQIC and the QM/UM committees, and ultimately, by DMS and the EQRO, IPRO.	
The Contractor shall continuously monitor its own performance on a variety of dimensions of care and services for Members, identify areas for potential improvement, carry out individual PIPs, undertake system interventions to improve care and services, and monitor the effectiveness of those interventions. The Contractor shall develop and implement PIPs to address aspects of clinical care and non-clinical services and are expected to have a positive effect on health outcomes and member satisfaction. While undertaking a PIP, no specific payments shall be made directly or	Full - The plan's P/P QI-005 outlines the process for PIPs, including types of projects (clinical and non-clinical), prioritizing topics to address specific needs of members and subsequent to population analysis, interventions, and monitoring status. The plan monitors quality and appropriateness of care and services through performance measures, surveys and medical record audits as described above and in P/P QI-005. Other than the two PIP topics described above, which are based on some monitoring of plan performance with regard to antidepressant adherence and ED utilization, there were no specific PIPs undertaken. Interventions include member and provider education and case management. Payment to providers was not part of planned interventions. The plan is addressing the entire plan membership and the subpopulation of members with depression, and is planning to evaluate potential disparities in care among	Full	P/P QI-005 outlines the process for PIPs, including types of projects (clinical and non-clinical), prioritizing topics to address specific needs of members and subsequent to population analysis, interventions, and monitoring status was provided onsite. The PIP topics were based on some monitoring of plan performance with regard to antidepressant adherence, ED utilization, care for ADHD and rates of hospital readmissions. The PIPs each address clinical topics, with one for PH and one for BH for	

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indirectly to a provider or provider group as an inducement to reduce or limit medically necessary services furnished to a Member. Clinical PIPs should address preventive and chronic healthcare needs of Members, including the Member population as a whole and subpopulations, including, but not limited to, Medicaid eligibility category, type of disability or special health care need, race, ethnicity, gender and age. PIPs shall also address the specific clinical needs that have a higher prevalence in the enrolled population. Non-clinical PIPs should address improving the quality, availability and accessibility of services provided by the Contractor to members and providers. Such aspects of service should include, but not be limited to, availability, accessibility, cultural competency of services, and complaints, grievances, and appeals.	subgroups of members with depression.		each year, as required. The PIP topics were approved by DMS and the EQRO, IPRO. No non-clinical/service PIPs have been proposed, though CCKY has addressed service improvements for internal purposes. To date, no additional PIPs have been required of CCKY by DMS. However, CCKY has participated in EQRO focus studies related to postpartum and newborn readmissions and EPSDT services.	
The Contractor shall develop collaborative relationships with local health departments, behavioral health agencies and other	Full - This is included in P/P QI-005. As reported in the second quarter's MCO reports, the plan's case managers collaborate with local health departments, school based health centers and community health care resources in	Full	Collaborative relationships are addressed in P/P QI-005, which was provided onsite. During the onsite interviews, CCKY described	

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community based health/social agencies to achieve improvements in priority areas. Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives.	coordinating care. These reports also note that case management staff collaborates with the Department for Child Based Services (DCBS) by presenting care plans if there are newly identified health problems and communicating with the state's regional case workers. Case Management also refers to the Commission for Children with Special Health Care Needs as applicable. Quarterly reports also note that the plan uses community resources such as shelters for outreach to the homeless population. The plan's Community Outreach Coordinators serve on homeless coalitions as well. As reported by onsite staff, MHNet is partnering with community mental health centers.		collaboration with local Departments of Public Health noting that it works with 196 LHDs in the 120 counties it serves, via local outreach staff. Initiatives include: substance abuse in pregnancy; community events such as baby showers and diabetes education; biweekly meetings to collaborate on provider relations and coverage issues. CCKY worked to address LHD concerns regarding Norton Health System participation in its network.	
The Department and the Contractor shall be committed to on-going collaboration in the area of service and clinical care improvements by the development of best practices and use of encounter data–driven performance measures.	Full - The plan provided documents and staff for the October onsite meeting and compliance review, and has been responsive to DMS comments regarding PIPs. The plan is using State- provided historical encounter data to identify high risk members.	Full	The QI Program Description states that CCKY will cooperate with DMS and the EQRO on improvements in services and clinical care concerns. CCKY has participated in EQRO focused studies and fulfilled QI contract requirements, including conducting PIPs, reporting performance measures and HEDIS, participating in EQRO focused	

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			studies, and submitting documentation and data for the annual review.	
The Contractor shall monitor and evaluate the quality of care and services by initiating a minimum of two (2) PIPs each year, including one relating to physical health and one relating to behavioral health. However, the Contractor may propose an alternative topic(s) for its annual PIPs to meet the unique needs of its Members if the proposal and justification for the alternative(s) are submitted to and approved by the Department. Additionally, the Department may require Contractor to (i) implement an additional PIP specific to the Contractor; if findings from an EQR review or audit indicate the need for a PIP, or if directed by CMS; and (2) assist the Department in one annual statewide PIP, if requested. In assisting the Department with implementation of an annual statewide PIP, the Contractor's participation shall be limited to providing the Department with	Full - The plan submitted two PIP proposals that are relevant to the plan's population and evaluation of plan data as noted in the rationale. PIPs address both behavioral health and physical health. The topics include Major Depression and ED Utilization. The annual statewide PIP has not yet been conducted, and not other PIPs have yet been required.	Full	As described previously, CCKY has two 2013 PIPs in progress and submitted proposals for two 2014 PIPs. The PIPs address behavioral health and physical health needs. PIP reports have been submitted as required. CCKY has not submitted an alternate PIP topic. DMS has not required CCKY to implement an additional PIP. DMS has not yet required CCKY to participate in a state-wide PIP, but MCOs have assisted with EQRO focused studies by providing requested data and documentation.	

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readily available data from the Contractor's region. The Contractor shall submit reports on PIPs as specified by the Department.				
The Department has identified four clinical areas and non-clinical topics for PIPs as a baseline assessment of Medicaid members in Appendix N.	Full - The plan initially identified topics for each of the four areas identified by the Department; after clarification, the plan submitted two proposals, one addressing Major Depression and the other ED Utilization, which were approved by the Department.	Full	CCKY initially proposed topics for each of the four areas identified by DMS. After clarification, CCKY submitted two proposals for 2013 PIPs: Major Depression and ED Utilization. These topics were approved by DMS. CCKY also submitted proposals for two 2014 PIPs: Hospital Readmissions and ADHD. Those topics were approved by DMS as well.	
The Contractor shall report on each PIP utilizing the template provided by the Department and must address all of the following in order for the Department to evaluate the reliability and validity of the data and the conclusions drawn:	Full - The plan submitted their PIP proposals on the template provided by the Department, and the proposals were approved. P/P QI -005 includes the elements below.	Full	CCKY submitted the PIP proposals on the template specified by DMS. The proposal topics were approved. P/P QI -005 addresses the elements below and was provided onsite.	
A. Topic and its importance to	Full - Topic relevance was well described in each revised	Full	Topic relevance was well described	

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enrolled members;	PIP.		in each of the four PIP proposals. CCKY revised the proposals based on EQRO recommendations.	
B. Methodology for topic selection;	Full - Rationale for the topic selection included statewide and plan-specific data to justify topic selection in each revised PIP.	Full	Rationale for the topic selection included statewide and plan-specific data to justify topic selection for each of the four PIP proposals. CCKY revised the proposals based on EQRO recommendations.	
C. Goals;	Full - Rationale for the topic selection included statewide and plan-specific data to justify topic selection in each revised PIP.	Full	Goals/targets for improvement are included in each of the four PIP proposals. CCKY revised the proposals based on EQRO recommendations.	
D. Data sources/collection;	Full - Data sources and collection procedures were described for each revised PIP.	Full	Data sources and collection procedures were described in each of the four PIP proposals. CCKY revised the proposals based on EQRO recommendations.	
E. Intervention(s) – not required for projects to establish baseline; and	Full - Interventions were described for each PIP initially that were somewhat passive and generic. Subsequent revisions included updated interventions that were active and targeted to the topic.	Full	Active and targeted interventions were described in each of the four PIP proposals though there were relatively passive interventions in some cases. CCKY revised the proposals based on EQRO recommendations.	

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F. Results and interpretations – clearly state whether performance goals were met, and if not met, analysis of the intervention and a plan for future action.	NA - Results are not yet available for the PIPs.	Substantial	Baseline results for the 2013 PIPs were submitted, but in some cases, were not clear, requiring clarification. CCKY followed the EQRO recommendations and was able to more clearly present the results. Plans for continuing interventions were presented in the PIP reports. A comparison to goals is not yet relevant as CCKY has only completed baseline measurements for its 2013 PIPs. **Recommendation for CCKY** Baseline results should be clearly presented in the PIP reports.	CCKY followed the EQRO recommendations and was able to more clearly present the results. Plans for continuing interventions were presented in the PIP reports. A comparison to goals is not yet relevant as CCKY has only completed baseline measurements for its 2013 PIPs. Baseline measurements completed for reports in 2014 will follow the recommendations for clearly comparing results to our goals.
The final report shall also answer the following questions and provide information on:				
A. Was Member confidentiality protected;	NA - proposal only submitted. This is included in P/P QI-005.	Full	The four PIP proposals address member confidentiality.	
B. Did Members participate in the performance improvement project?	NA - proposal only submitted. However, members are targeted for interventions in both PIPs.	Not Applicable	PIPs are still in process; however, member interventions are addressed in all PIPs.	
C. Did the performance	NA - proposal only submitted.	Not Applicable	PIPs are not yet completed.	

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improvement project include cost/benefit analysis or other consideration of financial impact;				
D. Were the results and conclusions made available to members, providers and any other interested bodies;	NA - proposal only submitted.	Not Applicable	PIPs are not yet completed.	
E. Is there an executive summary;	NA - proposal only submitted.	Not Applicable	PIPs are not yet completed.	
F. Do illustrations – graphs, figures, tables – convey information clearly?	NA - proposal only submitted.	Substantial	As indicated previously, the baseline results for the 2013 PIPs were sometimes not clear, requiring clarification. CCKY followed the EQRO recommendations and was able to more clearly present the results. **Recommendation for CCKY** Baseline results should be clearly presented in the PIP reports.	CCKY followed the EQRO recommendations and was able to more clearly present the results. Plans for continuing interventions were presented in the PIP reports. A comparison to goals is not yet relevant as CCKY has only completed baseline measurements for its 2013 PIPs. Baseline measurements completed for reports in 2014 will follow the recommendations for clearly comparing results to our goals.
Performance reporting shall utilize standardized indicators appropriate to the performance improvement area. Minimum performance levels	Full - The plan identified appropriate indicators based on HEDIS measures for the two PIP proposals that were submitted; goals were established and benchmarks from national data were identified in the rationales. Other	Substantial	CCKY used HEDIS measures for indicators where available and also selected Medication Possession Ratio for the MDD PIP. However,	CCKY followed the EQRO recommendations and was able to more clearly define the methodology.

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shall be specified for each performance improvement area, using standards derived from regional or national norms or from norms established by an appropriate practice organization. The norms and/or goals shall be predetermined at the commencement of each performance improvement goal and the Contractor shall be monitored for achievement of demonstrable and/or sustained improvement	relevant indicators, such as Medication Possession Ratio for adherence, are also included in the proposals.		in some cases, CCKY's methodology for use of the measures was not clear. CCKY was able to clarify the indicators with EQRO assistance. For HEDIS measures, the goals were based on benchmarks from national data. **Recommendation for CCKY** PIP methodology should be clearly presented in the PIP reports.	PIP methodology for reports in 2014 will follow the recommendations for clear presentation.
The Contractor shall validate if improvements were sustained through periodic audits of the relevant data and maintenance of the interventions that resulted in improvement. The timeframes for reporting:	NA - proposal only submitted.	Not Applicable	NA – the 2013 PIPs are in the baseline/interim phase and the 2014 PIPs are in the proposal stage.	
A. Project Proposal – due September 1 of each contract year. If PIP identified as a result of Department/EQRO review, the project proposal shall be due sixty (60) days after notification of requirement.	Full - The original proposals were submitted to DMS on September 1, 2012.	Full	The initial 2013 and 2014 PIP proposals were submitted on or before September 1st of the respective year (2012 or 2013).	
B. Baseline Measurement – due at	NA - proposal only submitted.	Full	The 2013 PIP baseline reports	

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a maximum, one calendar year after the project proposal and no later than September 1 of the contract year.			were submitted August 31, 2013.	
C. 1st Remeasurement – no more than two calendar years after baseline measurement and no later than September 1 of the contract year.	NA - proposal only submitted.	Not Applicable	The 2013 PIPs are currently in the first year. The 2014 PIPs are in the proposal/baseline measurement phase.	
D. 2nd Remeasurement – no more than one calendar year after the first remeasurement and no later than September 1 of the contract year.	NA - proposal only submitted.	Not Applicable	The 2013 PIPs are currently in the first year. The 2014 PIPs are in the proposal/baseline measurement phase.	
20.5 Quality and Member Access Committee				
The Contractor shall establish and maintain an ongoing Quality and Member Access Committee (QMAC) composed of Members, individuals from consumer advocacy groups or the community who represent the interests of the Member population.	Full - The plan has established a Quality and Member Access Committee as a subcommittee of the EQIC. The committee's membership includes members and consumer advocates. There are regional quarterly meetings of the QMAC. Onsite staff referenced a member advisory committee that meets at least twice a year; and acts as an ad hoc focus group. The plan provided QMAC minutes from 2/25/12, 9/12/12 and 12/19/12. The plan provided membership lists that include members, individuals from advocacy groups and community groups.	Full	The plan has established a Quality and Member Access Committee as a subcommittee of the EQIC. The committee's membership includes members and consumer advocates. There are regional quarterly meetings of the QMAC. The plan submitted QMAC meeting minutes. Membership lists reveal a variety of community interests	

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			represented.	
Members of the Committee shall be consistent with the composition of the Member population, including such factors as aid category, gender, geographic distribution, parents, as well as adult members and representation of racial and ethnic minority groups. Responsibilities of the Committee shall include:	Full - As per the QMAC Committee Description, membership will be consistent with plan population with regard to these factors. Meetings are held at different regional locations to facilitate regional representation. Membership lists reveal a variety of communities represented.	Full	Consistent with the Committee Description, the quarterly reports indicate that the QMAC sub-committee meets quarterly and the committee is comprised of members and consumer advocates who represent the interests of members. The QMAC meetings are held in four regional groups: South-West (Regions 1, 2 & 4), North Central (Region 31), North East (Regions 5 & 6), and East (Regions 7 & 8) so that members from across the state are represented.	
A. Providing review and comment on quality and access standards;	Full - This is included in the QMAC Committee Description. The role of the QMAC is to give feedback on topics such as marketing materials, customer service network access, benefit information and the health plan overall. QMAC minutes reveal review of the plan's provider directory, provider network status, and overview of QI, HEDIS measures and EPSDT standards.	Full	According to the Committee Description, the purpose of the committee is to interact with members and get feedback on quality of care, marketing materials, customer service, network access, benefit interpretation, and other areas that may affect the plan. QMAC meeting minutes include discussion and review of the QI Program Description and the QI	

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			Work Plan and review of the Provider Directory, overview of QI, HEDIS measures and EPSDT standards.	
B. Providing review and comment on the Grievance and Appeals process as well as policy modifications needed based on review of aggregate Grievance and Appeals data;	Minimal - This is included in the QMAC Committee Description. Evidence of QMAC review and comment on grievance and appeals policy and process was not available for review. **MCO Response:** As part of CoventryCares' quarterly Executive Improvement Committee (EQIC) meetings, the Appeals Department submits Quarterly Appeals and Grievance reports. These reports reflect the totals, trends, and key indicators in the data that are necessary to track the success of the department and the compliance with state/federal regulations. The Appeals Manager is responsible for presenting an overview and analysis of the data which is heard by the EQIC committee, and feedback is offered as needed. Please refer to attached policies, procedures, reports and minutes. Please note, the appeals and grievances reports with discussion are reflected in the EQIC minutes, not the Quality Member Access Committee (QMAC) minutes as identified in the EQRO report. Please refer to the attached EQIC minutes that reflect the reports, discussion, and follow-up. Please note, the follow-up action noted at the November 2012 meeting was reported at the February 2013 meeting (enclosed).	Full	The quarterly report 131030 contains QMAC minutes discussing the Appeals and Quality of Care Grievances processes. During the onsite interview, CCKY indicated that during the first committee year (2012) the QMAC was a statewide committee that involved too much travel for participants. CCKY changed to the regional model as described above. There are outreach coordinators in the four regions who recruit members and advocates including CSHCN advocates and coordinate meetings and communication. In Q4 2013, the QMAC reviewed the Member Handbook and member educational materials.	

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	Actions for improvement based on the findings and analysis of the 2012 grievances include; weekly CSO calls to discuss issues for how complaints are loaded and handled in the data system, and established action plans for necessary improvements and education; education to the grievance team on how to code issues appropriately; report on a quarterly basis numbers and types of grievances, along with analysis to outline key areas for improvement; work with provider relations to educate providers, and contract with those out of network when possible; work with the QI department for best practices in coding grievances correctly; establish a new electronic filing system for grievances so that we can ensure better compliance with letters and documentation; new processes designed to verify that correct letters have gone out, the correct department is resolving issues, and that resolution letters are sent out on all complaints; implement a new Quality Check tool for Grievances (verifies that we are compliant with all guidelines set forth by the Commonwealth of Kentucky and other regulatory bodies); update our data reports to more accurately measure timeframes and to identify complaints consistent with the definition in our policies and procedures. **IPRO Comments:** No change in review determination. It is noted in Section 19.4 that the plan monitors grievances and appeals. This contract requirement (20.5B) refers to review and comment on the grievance and appeal process			

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	by the QMAC.			
C. Review and provide comment on Member Handbooks;	Full - This is included in the QMAC Committee Description. QMAC minutes of 12/19/12 include evidence of QMAC review and comment on Member Handbooks.	Full	The QMAC bi-annual report to EQIC includes evidence of QMAC review and comment on the Member Handbook.	
D. Reviewing Member education materials prepared by the Contractor;	Full - This is included in the QMAC Committee Description. QMAC minutes of 12/19/12 include member feedback on the plan's website. The QMAC discussed educational materials on 4/25 and the requirement for translation and sixth grade reading level.	Full	Quarterly report 130430 includes QMAC review of the Member Handbook, member educational materials, the Provider Directory, and the CCKY website.	
E. Recommending community outreach activities; and	Full - This is included in the QMAC Committee Description. Community activities and the role of Community Outreach Coordinators were discussed on 4/25/12.	Full	Quarterly reports describe QMAC review of CCKY's community outreach activities such as the Baby Crib Program, Teen Mom Program and Smoking Cessation Program. The meeting minutes indicate that community advocates who were present at the meeting were encouraged to share their upcoming events	
F. Providing reviews of and comments on Contractor and Department policies that affect Members.	Full - This is included in the QMAC Committee Description. The QMAC minutes reveal review of member surveys and PIPs, Enhanced Case Management, Provider Representatives, and translation and interpreter services.	Full	QMAC minutes reveal review of EPSDT and lead screening programs, the Quality of Care process, review of PIPs and member handbook, provider directory and formulary. As noted previously, the QMAC reviewed the P/P for grievances and	

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			appeals.	
The list of the Members participating with the QMAC shall be submitted to the Department annually.	Full - The plan submitted a list of participating members in the second quarterly MCO reports. The plan submitted membership lists for April 2012, September 2012 and December 2012.	Full	CCKY submitted a list of QMAC members in the Q1 2014 Quarterly Report (reporting period 10/2013 – 12/2013). The member list reveals a variety of community interests represented.	
20.8 Assessment of Member and Provider Satisfaction and Access				
The Contractor shall conduct an annual survey of Members' and Providers' satisfaction with the quality of services provided and their degree of access to services. The member satisfaction survey requirement shall be satisfied by the Contractor participating in the Agency for Health Research and Quality's (AHRQ) current Consumer Assessment of Healthcare Providers and Systems survey ("CAHPS") for Medicaid Adults and Children, administered by an NCQA certified survey vendor.	Full - The Provider Satisfaction survey was conducted in 2012, and a report was provided. As per onsite staff and as reflected in the EQIC minutes and quarterly reports, the plan implemented a Transactional Survey initiated by CSO representatives, who send a web link to the provider, and a modified version (Health Plan Survey) sent to providers via fax blast. A planned member survey (CAHPS) is documented in the QI Work Plan for 2013.	Full	The plan conducted the CAHPS survey in 2013 and the Provider Satisfaction Survey in 2012 and 2013.	
The Contractor shall provide a copy of the current CAHPS survey tool to the Department.	Full - The QI Work Plan includes providing a copy of the CAHPS survey tool to NCQA and the EQIC in 2013; the plan indicated that all documents were approved by the Department in January 2013.	Full	The QI Work Plan includes administration and analysis of the CAHPS survey. The QI Work Plan indicates that the results were	

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			reported to SAC committee in September 2013. DSS is CCKY's survey vendor. The survey was submitted to DMS.	
Annually, the Contractor shall assess the need for conducting special surveys to support quality/performance improvement initiatives that target subpopulations perspective and experience with access, treatment and services.	Substantial - The plan has not yet conducted special member surveys, although surveys of members regarding Health Services are referenced in the UM Program Description. Onsite staff indicated that a behavioral health member survey had been conducted. **Recommendation for Coventry Cares** The plan should ensure that the need for special surveys that target subpopulations perspective and experience is assessed.	Full	CCKY reported that CM Satisfaction surveys are administered and that a POS type Customer Service Survey for both members and providers is being considered. The EQRO, IPRO, will be conducting a BH-focused survey.	
To meet the provider satisfaction survey requirement the Contractor shall submit to the Department for review and approval the Contractor's current provider satisfaction survey tool.	Full - The QI Work Plan indicates that the 2012 provider survey tool was submitted to DMS on July 30, 2012. The plan provided a report of the survey that included survey items.	Full	As per the Work Plan, the 2013 Provider Satisfaction Survey was scheduled in the third quarter. The tool and report were submitted to DMS.	
The Department shall review and approve any Member and Provider survey instruments and shall provide a written response to the Contractor within fifteen (15) days of receipt.				
The Contractor shall provide the Department a copy of all survey	Full - The plan provided a copy of the Provider Satisfaction Survey report; this report included methodology, response	Full	The plan provided a copy of the Provider Satisfaction Survey report	

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results. A description of the methodology to be used in conducting the Provider or other special surveys, the number and percentage of the Providers or Members to be surveyed, response rates and a sample survey instrument, shall be submitted to the Department along with the findings and interventions conducted or planned.	rates, and survey items. Member survey documents were approved by the Department in January 2013 as per the plan.		and the CAHPS survey results; these reports included methodology, response rates, and survey items.	
All survey results must be reported to the Department, and upon request, disclosed to Members.	Full - The Provider Satisfaction Survey report was provided by the plan. At the time of review, the member survey has not yet been conducted. There was no documentation of a request for survey results by members.	Full	CCKY submitted the Provider Satisfaction Survey report and included this in the pre-site documentation.	
37.5 QAPI Reporting Requirements The Contractor shall provide status reports of the QAPI program and work plan to the Department on a quarterly basis thirty (30) working days after the end of the quarter and as required under this section and upon request. All reports shall be submitted in electronic and paper format.	Full - As per the QI Program Strategy, quarterly status reports will be provided to the Department. Quarterly status reports, including an updated QI Work Plan, Quality Activity Summary, Indicator Monitoring, PIP status, Committee Activity, activities addressing EPSDT and pregnant women, and other required reports were submitted to DMS for 2012.	Full	The QI Program Description reports that the plan will make available to state Medicaid agencies as contractually required and upon request all data, clinical and other records/reports for review of quality of care, access and utilization issues including, but not limited to, activities related to External Quality Review (EQR), HEDIS ®, encounter data validation, and other related activities. CCKY submits Quarterly Status	

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			Reports to DMS are required.	
Reference the following documents for further information: **Appendix K** **Appendix N** **Appendix O**				

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Period of Review: January 1, 2013 – December 31, 2013
MCO: CoventryCares of Kentucky (CCKY)

Final Report 7/31/2014

Quality Assessment and Performance Improvement: Measurement and Improvement

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	81	9	0	0
Total Points	243	18	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.9**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Quality Assessment and Performance Improvement: Measurement and Improvement Suggested Evidence

Documents

QI Program Description
QI Work Plan
Evidence of member involvement in development of QI program
Annual PIP proposals and summary reports
Quality Improvement Committee description, membership, meeting agendas and minutes
Committee description, membership, meeting agendas and minutes for QMAC
Clinical Practice Guidelines
Provider Manual
Provider Newsletters
Provider Committee minutes
Innovative Program description and status report

Reports

Annual QI Evaluation Report
HEDIS Final Audit Report and IDSS rates
Healthy Kentuckians Outcomes Measures Report
CAHPS Report
Provider Satisfaction Survey Report
NCQA Accreditation Certificate and ISS Survey Report or status of accreditation
Performance Measure Reporting
Evaluation, analysis and follow-up of performance measure results
Evaluation, analysis and follow-up of provider compliance with Clinical Practice Guidelines
Monitoring of consistent application of practice guidelines for utilization management, enrollee education, and coverage of services

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CoventryCares of Kentucky (CCKY)
Grievance System (2014)

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Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
24. General Requirements for Grievances and Appeals				
The Contractor shall have a grievance system in place for Members that includes a grievance process related to "dissatisfaction" and an appeals process related to a Contractor "action," including the opportunity to request a State fair hearing pursuant to KRS Chapter 13B.				
The Contractor shall implement written policies and procedures describing how the Member may submit a request for a grievance or an appeal with the Contractor or submit a request for a state fair hearing with the State. The policy shall include a description of how the Contractor resolves the grievance or appeal.				
The Contractor shall provide to all Providers in the Contractor's network a written description of its grievance and appeal process and how providers can submit a grievance or appeal for a Member or on their own behalf.	Substantial - As per P/P APP-003, providers may contact the Appeals Department of Customer Service to file a grievance or appeal; providers who contact Customer Services will be educated regarding how to file an appeal and assisted as necessary. The process for provider grievances and appeals is also outlined in the Provider Manual. The Provider Manual describes the process for filing an appeal on a member's behalf, but does not appear to address filing a grievance on a member's behalf. The Member Handbook does indicate that a provider can file a grievance on a	Substantial	Provider Manual; Section 10 Complaint Process for Provider and Members describes the process for a provider to file an appeal on the member's behalf however, but does not include that a provider may file a grievance on a member's behalf or the process . P/P APP-002, 003, 004, 006, indicate that a grievance may be filed either orally or in writing within 30 days of the event, and that a member, representative or service provider have the right to file a grievance on behalf of the member.	CoventryCares of Kentucky will updated the Provider Manual to include the process for filing a grievance on a member's behalf in the Fall 2014 Provider Manual.

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	member's behalf with written consent. P/P APP-003 indicates a provider may file an appeal on member's behalf. **Recommendation for Coventry Cares** The plan should include the process for filing a grievance on a member's behalf in the Provider Manual.		**Recommendation for CCKY** As noted in the prior review, CCKY should include the process for filing a grievance on a member's behalf in the Provider Manual.	
The Contractor shall make available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.				
The Contractor shall name a specific individual(s) designated as the Contractor's Medicaid Member grievances or appeals coordinator with the authority to administer the policies and procedures for resolution of a grievance or appeal, to review patterns/trends in grievances or appeals, and to initiate corrective action.	Substantial - P/P APP-004 identifies the Quality Department as responsible for quality of care concerns, Provider Services for quality of service concerns and all other grievances are the responsibility of the Appeals and Grievances departments. P/Ps APP-004 and APP-002 identify the Appeals Coordinator in the Appeals and Grievances Department as responsible for member notifications and preparing the file for review by the appeals committee; the Appeals Coordinator	Full	P/P APP-004 Members Grievance, APP-002 Appeals-Members addresses the designated individual for member grievances and appeals. In the prior review, IPRO noted that CCKY should clarify roles and ensure coordination of staff so that categorizations are appropriate and consistent, and complete member notification and resolution occurs. The current file review results demonstrate that the recommendations from the prior review have been addressed. A new system and process was	

Grievance System *(See Final Page for Suggested Evidence)*				
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	is also responsible for grievances related to benefits, claims or services and for member notification regarding decisions for these grievances as well as quality of service grievances. The Customer Service representative is identified as responsible for identifying to which category a grievance belongs, and also for determining whether a dispute is eligible for an appeal and informing the member of timeframes if Customer Service receives the call as per APP-002. As noted above, Customer Service representatives also identify if a complaint is a quality of care concern or quality of service concern. Quality of service concerns are tasked to Provider Relations as per APP-004, and as per P/P QI-014, potential quality of care concerns are entered into the plan's Navigator system and are forwarded to the QI Department. P/P APP-004 indicates that management staff meets every week to review grievances to ensure appropriate triage and categorization and summarize trends. Findings are reported to the Executive Quality Improvement Committee (EQIC) to evaluate, track		implemented.	

Grievance System *(See Final Page for Suggested Evidence)*				
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	and trend the root cause of dissatisfaction. Trending of appeals does not appear specifically addressed in appeals policies, though included in Quality Improvement and UM documents. **Recommendation for Coventry Cares** With some overlap of responsibility of Customer Services and Appeals Coordinator, and some issues with member notifications and categorizations as well as lack of clear documentation of resolution in some grievances forwarded to other departments as described below, the plan should clarify roles and ensure coordination of staff so that categorizations are appropriate and consistent, and complete member notification and resolution occurs.			
The Contractor shall ensure that the individuals who make decisions on grievances or appeals are not involved in any previous level of review or decision-making. The Contractor shall also ensure that health care professionals with appropriate clinical expertise shall make decisions for the following:	Substantial - P/Ps APP-001 and APP-002 specify that Appeals Committee members cannot be involved in prior review or decision making. This is also stated in P/P APP-005 regarding subcontractors' grievances and appeals. For one EPSDT appeal file provided on the second day of review, there was no appeal documentation in the file (no	Full	P/P APP-002 addresses the requirement that individuals who make decisions on grievances or appeals are not involved in previous review or decision-making. P/P APP-001 addresses the requirement that individuals involved in the Appeal Review were not involved in the initial action and	

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	oversample for EPSDT). For all other grievances and appeals where applicable, individuals making decisions were not involved in previous review or decision making. **Recommendation for Coventry Cares** The plan should ensure that appeal files are complete and that individuals making decisions on appeals have appropriate clinical expertise.		who are not the subordinate of an individuals who made the initial action decision. Appeal File Review File review results demonstrate that files were complete and reviewers were appropriate. The full sample for each file type was available. Member Appeal File Review Seven files were reviewed. 7 of 7 files were reviewed by appropriate individuals. EPSDT Appeal File Review Five files were reviewed. 5 of 5 files were reviewed by appropriate individuals. Provider Appeal File Review Ten files were reviewed. 10 of 10 files were reviewed by appropriate individuals. Member Grievance – Random File Review Ten files were reviewed. 10 of 10 files were reviewed by appropriate individuals. No grievances were related to clinical issues. Member Grievance – Quality File	

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State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			Review Ten files were reviewed. 10 of 10 files were reviewed by appropriate individuals. Provider Grievance File Review Five files were reviewed. 5 of 5 files were reviewed by appropriate individuals. In the prior review, IPRO recommended that CCKY should ensure that appeal files are complete and that individuals making decisions on appeals have appropriate clinical expertise. The current file review demonstrates that the issue was addressed.	
A. An appeal of a Contractor denial that is based on lack of medical necessity;				
B. A Contractor denial that is upheld in an expedited resolution; and				
C. A grievance or appeal that involves clinical issues.	Substantial - Reviews of appeals based on clinical issues are reviewed by appropriate health care professionals as documented in APP-001, APP-002 and APP-005. As noted above, all files documenting appeals involving	Full	P/P APP-001 addresses clinical appeals reviewed by appropriate health care professionals not involved in the initial decision. P/P APP-002 addresses clinical appeals reviewed by appropriate	

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	clinical issues were reviewed by appropriate health care professionals. As per P/P APP-004, grievances that are phoned into Customer Service are determined to be quality of care concerns, i.e. based on treatment rendered, by the Customer Service representative. Written grievances are handled by the Appeals Coordinator in the Appeals and Grievance Department. Once determined to be a quality of care concern, the grievance is forwarded to the QI Department. Examples of quality of care issues in this policy include medical mismanagement, treatment delay, failure to provide timely equipment, medication or referral, inappropriate delayed response to recommended care and unauthorized release of PHI. As per QI-014, quality of care concerns are reviewed by the Quality Improvement Coordinator. If the case cannot be closed by the QI Coordinator, the grievance is referred to a physician reviewer, who may refer the case to the Quality Management/Utilization Management Committee. According		health care professionals who were not involved in the initial action and who are not the subordinate of an individual who made the initial action decision. As noted above, the grievance and appeal files evidenced appropriate reviewers. In addition, the documentation was clear as was the transition of the case between CCKY departments and/or vendors. In the prior review, IPRO recommended that CCKY should ensure that quality of care concerns are reviewed by appropriate clinical staff, and that documentation of investigation and resolution is coordinated between the Customer Services, Provider Services, Appeals and Quality Improvement Departments, so that appropriate investigation and resolution can be tracked. The file review findings indicated that the issues identified in the prior review were addressed: • Grievances were categorized appropriately (member vs. provider) • No provider grievances had a	

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	to P/P AP-004, management staff meets weekly to assess complaints and grievances and determine appropriate categorization, triage and resolution, with trends reported to the Quality Committee and Executive Quality Improvement Committee periodically. The plan's schedule of committee reports indicates quarterly reporting of grievances, and committee minutes reflect this reporting. Grievance File Review Of 30 member grievances and 15 provider grievances, there were 3 member grievances and 6 grievances that were identified as provider grievances that may have had a clinical component, although it was not entirely clear from the documentation. Three of these cases do not appear to have been reviewed by clinical staff (although documentation is not always clear). **Recommendation for Coventry Cares** The plan should ensure that quality of care concerns are reviewed by appropriate clinical staff, and that		clinical component • File documentation was easy to follow and clear with an excellent tracking sheet/case summary. • Referrals for QOC were evident • Coordination between units, as well as vendors, was evident in the documentation provided – loop was closed between hand off and return including due dates and follow up when indicated • Investigation was appropriate and thorough	

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	documentation of investigation and resolution is coordinated between the Customer Services, Provider Services, Appeals and Quality Improvement Departments, so that appropriate investigation and resolution can be tracked.			
The Contractor shall provide Members, separately or as a part of the Member handbook, information on how they or their representative(s) can file a grievance or an appeal, and the resolution process. The Member information shall also advise Members of their right to file a request for a state fair hearing with the Cabinet, upon notification of a Contractor action, or concurrent with, subsequent to or in lieu of an appeal of the Contractor action.				
The Contractor shall ensure that punitive or retaliatory action is not taken against a Member or service provider that files a grievance or an appeal, or a provider that supports a Member's grievance or appeal.	**Minimal -** The Member Handbook includes language that providers are not punished for supporting expedited appeals. Otherwise, submitted documents (policies, Member Handbook and Provider Manual) do not appear to include language that punitive action will not be taken against a Member or service provider who files a grievance or appeal. **MCO Response:** Grievance and Appeal policies (APP-001, 002, 003, 004, 005, 006, and 008) have been	Substantial	APP-001, APP-002, APP-003, APP-004 address the requirement that the plan will ensure that punitive or retaliatory action is not taken against a Member or service provider. The Member Handbook, Section 10 states: "CoventryCares of Kentucky does not punish your provider in any way for requesting a fast appeal or for supporting your request for a fast appeal." No information related to grievances was found.	CoventryCares of Kentucky will update the Provider Manual and Member Handbook to ensure that punitive action will not be taken against a member or service provider who files a grievance or appeal. This will be updated in the Fall 2014 Provider Manual and Member Handbook.

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State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	updated to state that no punitive action or retaliation will be taken towards a member or provider in response to an appeal. This is not limited to the expedited appeal process. Policies have been submitted to the Policies & Procedures Committee for review and approval. Copies of the draft policies are included.		Lack of retaliation related to filing appeals and grievances was not found in the Provider Manual or the provider contract. In the prior review, IPRO noted that the Member Handbook and Provider Manual did not include language that punitive action will not be taken against a Member or service provider who files a grievance or appeal. This was noted only in the Member Handbook as it relates to providers filing or supporting expedited appeals. However, as seen above, the Grievance and Appeal policies (APP-001, 002, 003, 004, 005, 006, and 008) were updated to state that no punitive action or retaliation will be taken towards a member or provider in response to an appeal. This is not limited to the expedited appeal process. **Recommendation for CCKY** CCKY should ensure that no retaliation is communicated to both members and providers related to both appeals and grievances by including this in the respective	

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			handbook/manual.	
24.1 Grievance Process				
A grievance is an expression of dissatisfaction about any matter or aspect of the Contractor or its operation, other than a Contractor action as defined in this contract.				
A Member may file a grievance either orally or in writing with the Contractor within thirty (30) calendar days of the date of the event causing the dissatisfaction. The legal guardian of the Member for a minor or an incapacitated adult, a representative of the Member as designated in writing to the Contractor, or a service provider acting on behalf of the Member and with the Member's written consent, have the right to file a grievance on behalf of the Member.	Minimal - P/P APP-004 indicates that a member may file a grievance within 30 calendar days after the event, and that a grievance can be submitted by the member, authorized representative or provider on their behalf by phone fax written communication or electronic communication. In P/P APP-004 it is noted that written or verbal member consent is needed for a representative to file a complaint on behalf of a member, rather than written consent. The Provider Manual includes the written consent requirement for filing appeals for members, but grievances are not addressed. It should be noted that there was one case file in the provider grievance sample that appeared to be a complaint by a home health provider on behalf of the member regarding home care. There was no consent documentation in the file, although	Substantial	Addressed in P/P APP-002, 003, 004, and 006. Provider Manual, Section 10 Complaint Process for Provider and Members describes the process for a provider to file an appeal on the member's behalf with a signed consent but does not address that a provider may file a grievance on a member's behalf, the process, or the need for consent. In the prior review, IPRO recommended that the requirement for written member consent for a provider to file a grievance on behalf of a member be included in the Provider Manual. This requirement was added to P/Ps but not to the respective handbook/manual for communication to members and providers.	CoventryCares of Kentucky will update the Provider Manual to include the requirement for written member consent for a provider to file a grievance on behalf of a member. This will be updated in the Fall 2014 Provider Manual.

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	it is not clear if the complaint was pursued, since the only documentation other than the complaint was a note requesting a review. **MCO Response:** Policies APP-002, 003, 004, 006, and 008 have been updated to state written consent is required to for an appeal or grievance filed on behalf of the member. (The contract states an oral appeal or grievance may be made but it must be followed in writing.) Policies will be reviewed and adopted by the Policies and Procedures Committee.		**Recommendation for CCKY** CCKY should ensure that providers' filing grievances on behalf of members with consent is communicated to both members and providers by including this in the respective handbook/manual.	
Within five (5) working days of receipt of the grievance, the Contractor shall provide the grievant with written notice that the grievance has been received and the expected date of its resolution.	**Minimal** - Written acknowledgment of receipt of the grievance within five days, to include expected resolution date, is included in P/P APP-004, and is to be sent by the Customer Service Representative or Appeal Coordinator. This information is also included in the Member Handbook. Grievance File Review Of 30 reviewed grievance files: • 7/30 files included an acknowledgement letter with expected resolution date sent	Substantial	P/P APP-004 addresses this requirement Grievance File Review File review demonstrated that issues related to acknowledgement letters identified in the prior review have been largely resolved, with the exception of a few cases where the acknowledgement letters were sent late. Member Grievance – Random File Review 8 of 10 files acknowledgment letter	1) CCKY has successfully implemented the Grievance Audit tool and has had successful quality scores. 2) CCKY has a grievance representative who acts as the liaison between departments regarding grievances. She assembles the electronic files for grievances and makes sure all required communication, research and corrective actions are carried out. 3) A tracking log has been required to track errors for CSO and the Grievance Liaison. CCKY has a back-up should the

Grievance System *(See Final Page for Suggested Evidence)*				
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	within 5 working days. • 1/30 cases had an acknowledgement letter with expected resolution date sent more than 5 working days after receipt. • 9/30 files included an acknowledgment letter that did not reference a resolution date, but rather had language thanking the member for keeping in touch. • 2/30 files included a notation that an acknowledgement letter was sent within five days, but there was no copy of the letter in the file so content (expected resolution date) could not be reviewed. • There were 10/30 files with no acknowledgment letter or mention of letter. Five of these cases documented phone calls with members. In one case, the complaint was resolved on the same day but there was no acknowledgment letter or resolution letter. Some cases had very sparse documentation. One of these cases had a notation that the member should be told to appeal after calling to complain about misinformation on a denial letter, but there is no other		were sent timely. <u>Member Grievance – Quality File Review</u> 9 of 10 files acknowledgment letter were sent timely. <u>Provider Grievance File Review</u> 5 of 5 acknowledgement letters were sent timely. In response to prior findings, CCKY implemented several new processes and procedures and developed a new system for processing grievances including: ▪ Implementation of Quality Check tool for Grievances. Quality Checks are done weekly and metrics are reviewed by senior management with corrective action taken, as needed. ▪ A team member has been assigned responsibility for tracking grievances and ensuring timeliness, compliance, and quality. Other team members are trained as back-up. ▪ The responsible staff member uses daily reports to monitor inquiries coded as grievances	Liaison be out of office. 4) The Grievances and Appeals Manager, Grievance Liaison and back-up ALL review daily reports to make sure all necessary communications are sent, and that complaints closed by CSO are caught and handled correctly. *** As an addition, a Complaint Checklist function will be added to our systems. This will allow for additional data to be tracked. It will also **prevent CSO, or another third party from closing an issue coded as a complaint.** Only the G&A Department can close the issues. Coding these issues as complaints will also force an issue to be sent to the proper location to be worked. This feature should do away with incorrectly handled complaints.

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	documentation in the file. • The remaining 1/30 files noted that an acknowledgment should be sent, but there was no documentation that it was sent and no copy of a letter. **MCO Response:** CoventryCares of Kentucky has made many improvements to the Grievance System in 2013. Improvements include: 1) Implementation of Quality Check tool for Grievances. Management performs the Quality Check weekly. Metrics are submitted to senior management to review and identify corrective action, as needed. 2) A team member has been assigned to be fully responsible for handling Grievances. Remaining team members are full trained in handling Grievances for back-up and during the principal employee's leave. This individual dedicates their time to tracking grievances and ensuring timeliness, compliance, and quality.		and any issues that require action. The staff member checks and if a complaint is closed without all necessary components, the case will be reviewed and re-coded correctly or re-opened as a complaint and acknowledged. The report is viewed by the Manager and Coordinator. A weekly report is sent to the grievance coordinator for another check. ▪ A Tracking Log was created to track issues opened as complaints but not worked. The Tracking Log assists the G/A manager to identify staff training issues for both G/A and call center staff. The current file review reflected the improvements. It was noted in the case files that the tracking system was calculating the due dates incorrectly (+/- 1 – 2 days). This did not impact the timeliness of acknowledgements or resolutions for the files reviewed. **Recommendation for CCKY** Acknowledgment letters should be	

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	3) A Tracking Log has been created to track issues opened as complaints but not worked as complaints. The Tracking Log assists the Grievance and Appeals manager in identifying issues related to staff training for the Grievance and Appeals team as well as the call center staff. Issues are reported to the appropriate department's management to reinforce appropriate handling of issues. 4) The person responsible for grievances will use daily grievance reports to monitor inquiries coded as grievances, and issues that require action. If any complaint is closed that does not contain all of the necessary components, the case will be reviewed and either re-coded correctly, or will be re-opened as a complaint and acknowledged. This report will be viewed by the Manager and Coordinator to make sure nothing is missed. A weekly report will also be sent to the grievance coordinator so they can double check the closures.		issued within 5 working days of receipt of the grievance.	

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The investigation and final Contractor resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the Contractor and shall include a resolution letter to the grievant.	Minimal - Resolution of grievances within 30 calendar days of the date of receipt is included in P/P APP-004, and the resolution is to include a resolution letter to the grievant. As per P/P QI-014, this timeframe applies to a quality of care investigations also. <u>Grievance File Review</u> Of 30 reviewed member grievance files: • 14/30 were clearly resolved within 30 calendar days with a written resolution letter. • There were 5/30 cases with written resolution notices that were sent >30 calendar days after receipt of the grievance. • There were 3/30 cases noted to be resolved within 30 days, but there was no documented resolution letter. A notation indicated that a message was left on an answering machine for one case, and another case was resolved on the same day. • For 8/30 files, there was no written resolution notice and no clearly documented resolution date, and in some cases no clear resolution.	Full	P/P APP-004 addresses this requirement. <u>Grievance File Review</u> A total of 25 files were reviewed (10 member random grievances, 10 member quality grievances, and 5 provider grievances). 25 of 25 were resolved timely. CCKY implemented improvements and issues identified in 2013 were resolved.	

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State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	In some cases documentation was very sparse. In some cases the complaint may have been handled by Provider Services or Quality Improvement, but there is no evidence in some of the available files as noted above that the complaint was resolved, resolved in a timely fashion and the member notified. P/P APP-004 indicates that the complaint research and resolution should be thoroughly detailed in comments once the complaint is resolved by the appropriate department. **MCO Response**: As above.			
The Contractor may extend by of up to fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the extension within two working days of the decision to extend the timeframe.	**Minimal -** This is included in appeal P/Ps APP-001 and APP-002, but there is no reference to extension in the grievance policy APP-004. The plan did provide a sample letter informing the member of the need for an extension for grievance investigation. The sample letter states that more information is needed from the member; there does not appear to be space to describe other reasons for the extension. Of reviewed grievances, there were none for which an	Full	P/P APP-004 and 003 address this requirement. Sample letters were not submitted for review. CCKY indicated that the letters were to be submitted to DMS for approval. However, letters in the files reviewed were appropriate. <u>Grievance File Review</u> A total of 25 files were reviewed: 10 member random grievances, 10 member quality grievances, and 5 provider grievances. One extension	

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	extension was requested. **MCO Response:** Grievance policies (APP-003,004) have been updated to include the 14 day extension language. Letters KYGA00001 and KYGA00013 (extension letters) are being updated through the plan's letter workgroup to reflect the reason for the extension. The letters will be submitted the Department for approval as required by our contract.		was granted (member quality grievance file). The letter was in the current format with the reason for extension.	
Upon resolution of the grievance, the Contractor shall mail a resolution letter to the Member. This resolution letter may not take the place of the acknowledgment letter referred to in Section B above, unless the resolution of the grievance has been completed and can be communicated to the Member in the same correspondence acknowledging receipt of the grievance. The resolution letter shall include, but not be limited to, the following:	**Minimal** - Per P/P APP-004, the Appeals Coordinator is responsible for a resolution letter. P/P APP-004 indicates that even for Provider Relations-investigated Quality of Service issues, the resolution letter is sent out by the Appeals Coordinator. Files Of 30 member grievances, 19 files included documentation of a resolution letter as noted above. P/P QI-014 indicates that the QI Coordinator sends out member resolution letters for quality of care concerns.	Full	P/P APP-004 addresses the Appeals Coordinator's responsibility to send resolution letters. CCKY implemented improvements and issues identified in 2013 were resolved. <u>Grievance File Review</u> A total of 25 files were reviewed: 10 member random grievances, 10 member quality grievances, and 5 provider grievances. File review demonstrated that issues related to resolution notices have been resolved. All files contained resolution notices.	

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	MCO Response: CoventryCares of Kentucky has a process that handles a Quality of Service complaint through our provider relations department and Quality of Care complaints through our Quality Improvement department. Policy APP-004 and QI-014 are consistent with this process. In order to improve out instances of compliance, we have made the following changes to the Grievance system: See above.			
A. All information considered in investigating the grievance;				
B. Findings and conclusions based on the investigation; and				
C. The disposition of the grievance.	Substantial - Disposition is included in P/P APP-004 and sample grievance and quality of service decision letters provided by the plan. Files Of the 19/30 cases with a resolution notice, 19/19 included the disposition. One disposition was somewhat unclear; the member had been billed by a hospital that refused	Full	P/P APP-004 addresses the requirement that the decision letter includes the disposition of the grievance. File review demonstrated that issues related to resolution notices have been resolved. All files contained resolution notices with the required components. Issues related to disposition were	

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	to bill Coventry. The notice indicated that the hospital had that right. The notice did not provide clarification on the implication for the member, and the member called to clarify weeks later. **Recommendation for Coventry Cares** The MCO should ensure that all member concerns are addressed.		resolved. Issues related to clarity were addressed. The language was clear and reading level appropriate. In the prior review, IPRO recommended that the MCO ensure that all member concerns are addressed. As noted above, issues were resolved.	
24.2 Appeal Process				
An appeal is a request for review by the Contractor of a Contractor action.				
A. An action for purpose of an appeal is:				
(1) the denial or limited authorization of a requested services, including the type or level of service;				
(2) the reduction, suspension, or termination of a previously authorized service;				
(3) the denial, in whole or in part, of payment for a service;				
(4) the failure of the Contractor to provide services in a timely manner, as defined by the Department or its designee; or				
(5) the failure of the Contractor to complete the authorization request in a timely manner as defined in 42 CFR 438.408.				

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
(6) for a resident of a rural area with only one Contractor, the denial of a Member's request to exercise his or her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the network.				
B. The Contractor shall mail a notice of action to the Member or service provider. The notice shall comply with 42 CFR 438.10(c) regarding language and (d) regarding format and shall contain, but not be limited to, the following:	Substantial - Notice of action content is described in P/P UM-008, Notice of Action. Appeal File Review Of 15 member appeals, one EPSDT appeal did not contain documentation in the file and there was no EPSDT oversample. This file could not be reviewed for notice of action. The 14/15 remaining files included a notice of action. 10/10 provider files included notice of action. **Recommendation for Coventry Cares** The plan should ensure that appeal files include complete documentation and that the notice of action is included.	Full	P/P UM-008 addresses this requirement CCKY implemented improvements and the file review demonstrated that issues were resolved. Appeal File Review 22 files were reviewed (7 Member, 5 EPSDT, and 10 Provider). All files met the requirements for notice of action. In the prior review, IPRO recommended that CCKY ensure that appeal files include complete documentation and that the notice of action is included. As described above and as indicated by the file review results, CCKY implemented improvements and issues were resolved.	

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
(1) the action the Contractor has taken or intends to take;				
(2) the reasons for the action;				
(3) the Member's or the service provider's right, as applicable, to file an appeal of the Contractor action through the Contractor;				
(4) the Member's right to request a state fair hearing and what the process would be;				
(5) the procedures for exercising the rights specified;				
(6) the circumstances under which expedited resolution of an appeal is available and how to request it; and				
(7) the Member's right to have benefits continue pending resolution of an appeal or state fair hearing, how to request the continuation of benefits, and the circumstances under which the Member may be required to pay the costs of continuing these benefits.				
The notice shall be mailed within ten (10) days of the date of the action for previously authorized services as permitted under 42 CFR 431.213 and 431.214, and within fourteen (14) days of the date of the action for newly requested services. Denials of Claims that may result in Member financial liability require immediate notification.	Substantial - UM-008 Notice of Action policy includes notice of action within 10 days for previously authorized services. Denial of payment is made on the same day as per policy UM-013, Timeframes for Notice of Action. The timeframe of	Full	Addressed in UM-008 Notice of Action and UM-013 Timeframes for Notice of Action. In the prior review, IPRO recommended that CCKY include timeframes for notice of action for	

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	fourteen days for newly requested services does not appear evident in policies or the Member Handbook. **Recommendation for Coventry Cares** The plan should include timeframes for notice of action for newly requested services in policies.		newly requested services in policies. The current P/Ps address each of the required timeframes.	
C. A Member may file an appeal either orally or in writing of a Contractor action within thirty (30) calendar days of receiving the Contractor's notice of action. The legal guardian of the Member for a minor or an incapacitated adult, a representative of the Member as designated in writing to the Contractor, or a provider acting on behalf of the Member with the Member's written consent, have the right to file an appeal of an action on behalf of the Member. The Contractor shall consider the Member, representative, or estate representative of a deceased Member as parties to the appeal.				
D. The Contractor has thirty (30) calendar days from the date the initial oral or written appeal is received by the Contractor to resolve the appeal. The Contractor shall appoint at least one person to review the appeal who was not involved in the initial decision and who is not the subordinate of any person involved in the initial decision.	Substantial - As per P/P APP-002, appeal resolution will occur within 30 calendar days. Appeal File Review Of 15 member appeals, 14 included appeal documentation. Of these 14, one was resolved in more than 30 days (Received 11/8, resolution 12/13.) For another member the	Full	P/P AAP-002 addresses the requirement. Appeal File Review 22 files were reviewed (7 Member, 5 EPSDT, and 10 Provider). All files met the requirements for appropriate reviewer. All appeals were resolved timely.	

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	appeal was resolved within 30 days of receipt of consent for the provider to file the appeal. (Provider appeal received 7/30, consent received 8/13, and resolution 9/10). All 14 appeals were reviewed by a reviewer independent of the initial decision. **Recommendation for Coventry Cares** The plan should ensure resolution of appeals within 30 calendar days of receipt.		In the prior review, IPRO recommended that CCKY ensure resolution of appeals within 30 calendar days of receipt. The file review results indicate that this issue was resolved.	
E. The Contractor shall have a process in place that ensures that an oral or written inquiry from a Member seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). An oral appeal shall be followed by a written appeal that is signed by the Member within ten (10) calendar days. The Contractor shall use its best efforts to assist Members as needed with the written appeal and may continue to process the appeal.				
F. Within five working days of receipt of the appeal, the Contractor shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. The Contractor shall confirm in writing receipt of oral appeals, unless the Member or the service provider requests an expedited resolution.	Substantial - As per P/P APP-002 and APP-003, acknowledgement letters are sent within 5 working days, and include expected date of resolution, which is included in the plan's template acknowledgment letter. Appeal File Review Of 15 member appeals, 14 included	Full	Addressed in P/P APP-002. Appeal File Review 22 files were reviewed (7 Member, 5 EPSDST, and 10 Provider). All files met the requirements for timeliness of acknowledgment and notices included the expected date of resolution.	

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	appeal documentation (EPSDT appeal did not). 12/14 member appeal files with appeal documentation included acknowledgement letters within 5 days. One acknowledgment letter was not sent within 5 working days (received 9/10, letter sent 9/19.) One EPSDT dental appeal file did not include an acknowledgment letter. As noted above, written consent for one appeal by a provider on a member's behalf was received after 13 days; the acknowledgement letter was sent within 5 working days of receipt of this consent. **There was one expedited member appeal that had a written resolution within one day and therefore did not require written acknowledgement**. 9/10 provider appeals included acknowledgement within 5 working days; 1/10 was sent within 7 days (received 8/29, acknowledgement 9/11). **<u>Recommendation for Coventry Cares</u>** The plan should ensure that the member receives written notice of		In the prior review, IPRO recommended that CCKY ensure that the member receives written notice of receipt of appeal (acknowledgement) within 5 days and that the notice includes the expected date of resolution. The file review results indicate that this issue was resolved.	

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	receipt of appeal within 5 days and includes expected date of resolution.			
G. The Contractor may extend the thirty (30) day timeframe by fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information, and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the extension and the reason for the extension within two working days of the decision to extend the timeframe.				
H. The Contractor shall provide the Member or the Member's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing.				
I. The Contractor shall provide the Member or the representative the opportunity, before and during the appeals process, to examine the Member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The Contractor shall include as parties to the appeal the Member and his or her representative, or the legal representative of a deceased Member's estate.				
J. For all appeals, the Contractor shall provide written notice within the thirty (30) calendar-day timeframe for resolutions to the Member or the provider, if the provider filed the appeal. The written notice of the appeal resolution shall include, but not be limited to,	Substantial - The 30 day timeframe for resolution of appeals is included in APP-002 and APP-003, as well as the Member Handbook.	Full	Addressed in P/P APP-002. <u>Appeal File Review</u> 22 files were reviewed (7 Member, 5 EPSDST, and 10 Provider). All files	

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
the following information:	Appeal File Review For member appeals, 14/15 files included appeal documentation. 13 member appeal files included a written notice of resolution within 30 days. One file included a resolution letter dated more than 30 days from receipt of the grievance (received 11/8, resolution 12/13). 8/10 provider files included resolution letters within 30 calendar days. One case was resolved within 30 days, but the written resolution was dated 33 days from receipt (received 11/8, resolved 12/7, written notice 12/12.) One provider file was incomplete and did not include a resolution or written notice. **Recommendation for Coventry Cares** The plan should include resolution letter copies in file documentation.		met the requirements for timeliness of resolution and resolution notice. In the prior review, IPRO recommended that CCKY ensure that the resolution letter is included in the file documentation. The file review results indicate that this issue was resolved.	
(1) the results and reasoning behind the appeal resolution; and				
(2) the date it was completed.				
K. The written notice of the appeal resolution for appeals not resolved wholly in favor of the Member				

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
shall include, but not be limited to, the following information:				
(1) the right to request a state fair hearing and how to do so;	Substantial - Of the 5 member appeals with an adverse (upheld or partial) determination, 4/5 included state fair hearing language. 1/5 files with a decision not entirely in member's favor did not appear to contain fair hearing language in the notice of resolution. **Recommendation for Coventry Cares** Fair hearing language should be included in resolution letters for decisions not entirely decided in the member's favor.	Full	Addressed in P/P APP-002. Appeal File Review 22 files were reviewed (7 Member, 5 EPSDT, and 10 Provider). 16 of 22 appeals were upheld. All upheld appeals met the requirements that the resolution notice contain the right to a State Fair Hearing (SFH) and how to do so. In the prior review, IPRO recommended that CCKY ensure that the resolution letter for upheld appeals contain the right to SFH. The file review results indicate that this issue was resolved.	
(2) the right to request receipt of benefits while the state fair hearing is pending, and how to make the request; and	Substantial - 1/5 files with a decision not entirely in member's favor does not appear to contain fair hearing language in the notice of resolution. **Recommendation for Coventry Cares** The plan should ensure that the notice of resolution for decisions not wholly in the member's favor include fair hearing information as specified.	Full	P/P APP-002 addresses this requirement. Appeal File Review 22 files were reviewed (7 Member, 5 EPSDT, and 10 Provider). 16 of 22 appeals were upheld. All upheld appeals met the requirements that the resolution notice contain the right to continuation of benefits while the SFH is pending.	

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			In the prior review, IPRO recommended that CCKY ensure that the resolution letter for upheld appeals contain the right to continuation of benefits while the SFH is pending. The file review results indicate that this issue was resolved.	
(3) that the Member may be held liable for the cost of continuing benefits if the state fair hearing decision upholds the Contractor's action.	Substantial - 1/5 files with a decision not entirely in member's favor does not appear to contain fair hearing language in the notice of resolution. **Recommendation for Coventry Cares** The plan should ensure that the notice of resolution for decisions not wholly in the member's favor include fair hearing information as specified.	Full	P/P APP-002 addresses this requirement. Appeal File Review 22 files were reviewed (7 Member, 5 EPSDT, and 10 Provider). 16 of 22 appeals were upheld. All upheld appeals met the requirement that the resolution notice contain notice that the member may be liable for the cost of continued benefits if the SFH upholds the decision. In the prior review, IPRO recommended that CCKY ensure that the resolution letter for upheld appeals contain that the member may be liable for the cost of continued benefits if the SFH upholds the decision. The file review results indicate that this issue was resolved.	

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
L. The Contractor shall continue the Member's benefits if all of the following are met:				
(1) the Member or the service provider files a timely appeal of the Contractor action or the Member asks for a state fair hearing within 30 days from the date on the Contractor notice of action;	**Non-Compliance -** The Member Handbook and P/P APP-002 indicate that if a member wants their benefits to continue during a state hearing they must file within 10 days of notice of action or appeal decision rather than 30 days from the notice of action. This 10 day timeframe is not included in reference to state hearing in the KYGA00008 upheld appeal decision letter. **MCO Response:** Letter number KYGA00008 is being revised by the plan's letter team to include the 10 day timeframe. The letter will be submitted to the Commonwealth for approval.	Minimal	CCKY revised P/P APP-002 and letter KYGA00008 to include the requirements for continuation of benefits. The 10 day timeframe has been deleted. Member Handbook continues to state that if benefits are to continue during the appeal process, the request must be filed within 10 days. As noted above, CCKY revised its P/P and letter KYGA00008 to meet the requirements for continuation of benefits. However, the 10/2013 version of the Member Handbook still states that the SFH must be requested within 10 days for benefits to continue. **Recommendation for CCKY** The Member Handbook should be revised to delete the 10 day timeframe.	CoventryCares of Kentucky will revise the Fall 2014 Member Handbook to delete the 10 day timeframe.
(2) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;				
(3) the services were ordered by an authorized service				

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
provider;				
(4) the time period covered by the original authorization has not expired; and				
(5) the Member requests extension of the benefits.				
M. The Contractor shall provide benefits until one of the following occurs:				
(1) The Member withdraws the appeal;	Non-Compliance - This language does not appear in the Member Handbook or policy APP-002 or APP-003. **MCO Response:** Policies APP-002 and APP-003 have been updated to reflect that a member may request a continuation of benefits. The policies will be presented to the plan's Policies & Procedures Committee for review and approval. The Member Handbook is being revised to reflect continuation of benefits. The Member Handbook will be submitted to the Commonwealth for review and approval.	Full	CCKY revised P/P APP-002 to address the requirement for conditions under which benefits may be discontinued. The Member Handbook states that benefits will continue during appeal/SFH as long as the member eligible for Medicaid.	
(2) Fourteen (14) days have passed since the date of the resolution letter, provided the resolution of the appeal was against the Member and the Member has not requested a state fair hearing or taken any further action;	Non-Compliance - This language does not appear in the Member Handbook or policy APP-002 or APP-003.	Full	CCKY revised P/P APP-002 to address the requirement for conditions under which benefits may be discontinued. The Member Handbook states that benefits will	

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	MCO Response: Policies APP-002 and APP-003 have been updated to reflect that a member may request a continuation of benefits. The policies will be presented to the plan's Policies & Procedures Committee for review and approval. The Member Handbook is being revised to reflect continuation of benefits. The Member Handbook will be submitted to the Commonwealth for review and approval.		continue during appeal/SFH as long as the member eligible for Medicaid.	
(3) The Cabinet issues a state fair hearing decision adverse to the Member;	Minimal - This language does not appear explicitly in the Member Handbook or P/Ps APP-002 or APP-003, although there is reference that the member is responsible for paying for services if there is an adverse state fair hearing determination. **MCO Response:** Policies APP-002 and APP-003 have been updated to reflect that a member may request a continuation of benefits. The policies will be presented to the plan's Policies & Procedures Committee for review and approval. The Member Handbook is being revised to reflect continuation of benefits. The Member Handbook will be submitted to the	Full	CCKY revised P/P APP-002 to address the requirement for conditions under which benefits may be discontinued. The Member Handbook states that benefits will continue during appeal/SFH as long as the member eligible for Medicaid.	

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	Commonwealth for review and approval.			
(4) The time period or service limits of a previously authorized service has expired.				
N. If the final resolution of the appeal is adverse to the Member, that is, the Contractor's action is upheld, the Contractor may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b).				
O. If the Contractor or the Cabinet reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires. If the Contractor or the Cabinet reverses a decision to deny, limit or delay services and the Member received the disputed services while the appeal was pending, the Contractor shall pay for these services.	Substantial - P/P APP-002 indicates that if a decision is in favor of the member, the Appeal Coordinator must update the necessary authorization or notify Health Services to do so. Language regarding payment for services if adverse decision is reversed and prompt and expeditious authorization is not evident in policies. **Recommendation for Coventry Cares** The MCO should include specific language regarding authorization following reversals of decision in which services were not furnished while appeal was pending into	Full	Addressed in P/P APP-002. In prior review, IPRO recommended that CCKY include language regarding authorization for services were not furnished while appeal was pending into policies. The policy has been revised.	

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	policies.			
24.3 Expedited Resolution of Appeals				
An expedited resolution of an appeal is an expedited review by the Contractor of a Contractor action.				
A. The Contractor shall establish and maintain an expedited review process for appeals when the Contractor determines that allowing the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. Such a determination is based on:				
(1) a request from the Member;	Substantial - P/P AP-001 includes member request for expedited appeal, and the process is described in the Member Handbook. There was one expedited appeal among reviewed case files that was a request from a member. P/P APP-001 notes that members must be educated on the right to appeal if they contact Member Services. **Recommendation for Coventry Cares** In one grievance file, the member is concerned about denial of injections and is told he could file an appeal, but the member indicates that he is	Full	P/P AP-001 Expedited Appeals addresses the requirements for expedited appeal. The Member Handbook addresses this requirement under Expedited (Faster) Appeal. Appeals File Review 22 appeals were reviewed and none involved expedited appeals.	

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	in too much pain to wait for resolution. There is no documentation that expedited appeal was discussed with the member. While expedited appeal may not have been appropriate for this member, the plan could consider addressing how and when expedited appeals should be discussed with members who contact the plan dissatisfied with an adverse action.			
(2) a provider's support of the Member's request;				
(3) a provider's request on behalf of the Member; or				
(4) the Contractor's independent determination.				
The Contractor shall ensure that the expedited review process is convenient and efficient for the Member.				
B. The Contractor shall resolve the appeal within three working days of receipt of the request for an expedited appeal. In addition to written resolution notice, the Contractor shall also make reasonable efforts to provide and document oral notice.				
C. The Contractor may extend the timeframe by up to fourteen (14) calendar days if the Member requests the extension, or the Contractor demonstrates to the Department that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the delay.				

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
E. The Contractor shall ensure that punitive action is not taken against a Member or a service provider who requests an expedited resolution or supports a Member's expedited appeal.	Substantial - The Member Handbook indicates that providers are not punished for requesting or supporting a member's request for expedited appeal. AAP-001 does not address this issue. Punitive action against a member is not referenced in the Member Handbook or APP-001. **Recommendation for Coventry Cares** The plan should include assurance that punitive action will not be taken against a member who requests an expedited appeal in the Member Handbook and policy.	Minimal	P/P APP-002 states that CCKY will not take any punitive action or retaliate in any way as a result of a member or member's representative filing or supporting an appeal, whether expedited or otherwise. The Member Handbook states that CCKY will not punish the provider for filing an expedited appeal or supporting the member's expedited appeal request. Retaliation against the member is not addressed. **Recommendation for CCKY** IPRO previously recommended that CCKY include assurance that punitive action will not be taken against a member who requests an expedited appeal in the Member Handbook and policy. P/P AAP-001 addresses the requirement but the Handbook does not.	CoventryCares of Kentucky will update the Fall 2014 Member Handbook to include assurance that punitive action will not be taken against a member who requests an expedited appeal.
F. The Contractor shall provide an expedited resolution, if the request meets the definition of an expedited appeal, in response to an oral or written request from the Member or service provider on behalf of the Member.				
G. The Contractor shall inform the Member of the limited time available to present evidence and				

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
allegations in fact or law.				
H. If the Contractor denies a request for an expedited resolution of an appeal, it shall:				
(1) transfer the appeal to the thirty (30) day timeframe for standard resolution, in which the thirty (30) day period begins on the date the Contractor received the original request for appeal; and				
(2) make reasonable efforts to give the Member prompt oral notice of the denial, and follow up with a written notice within two-calendar days.	Substantial - P/P AP-001 documents that the Appeal Coordinator will call the member if an appeal does not meet expedited criteria and is converted to a standard appeal, and that written notice of denial of expedited appeal will be sent within 2 calendar days. The Member Handbook indicates that the plan will call or write to the member if the regular appeal process will be followed. There were no case files in the sample that were converted from expedited to standard appeals. **Recommendation for Coventry Cares** The plan should amend the Member Handbook information regarding a denied request for expedited appeal to be consistent with policy and the contract requirements.	Full	Addressed in P/P AP-001. The Member Handbook states that the Appeal Coordinator will call the member if the appeal does not meet expedited requirements. Appeal File Review No files involved requests for expedited appeal that were converted to standard appeals. In prior review, IPRO recommended that CCKY amend the Member Handbook to address a denied request for expedited appeal. As noted above, the Member Handbook contains the required language.	
I. The Contractor shall document in writing all oral				

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
requests for expedited resolution and shall maintain the documentation in the case file.				
24.4 State Hearings for Members				
A Member may request a State Fair Hearing if he or she is dissatisfied with an Action that has been taken by the Contractor, within thirty (30) days of receiving notice of the Action or within thirty (30) days of the final decision by the Contractor.				
All documents supporting the Contractor's Action must be received by the Department no later than five (5) days from the date the Contractor receives notice from the Department that a State Fair Hearing has been filed. These records shall be made available to the Member upon request by either the Member or the Member's legal counsel. The Department will provide the Member with a hearing process that shall adhere to 907 KAR 1:563, 42 CFR 438 Subpart F and 42 CFR 431 Subpart E.				
Failure of the Contractor to comply with the State Fair Hearing requirements of the state and federal Medicaid law in regard to an Action taken by the Contractor or to appear and present evidence will result in an automatic ruling in favor of the Member.				
27.8 Provider Grievances and Appeals				
The Contractor shall establish and maintain written policies and procedures for the filing of Provider grievances and appeals. A provider shall have the right to file a grievance or an appeal with the Contractor. Provider grievances or appeals shall be resolved within	Minimal - P/P APP-003 addresses provider grievances and appeals. Coventry also identifies a category called "claims review", which is not a grievance or appeal but a process for	Full	Addressed in P/P APP-003. <u>Provider Appeal and Grievance File Review</u> As described previously, 10 provider	

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
thirty (30) calendar days. If the grievance or appeal is not resolved within thirty (30) days, the Contractor shall request a fourteen (14) day extension from the provider. If the Provider requests the extension, the extension shall be approved by the Contractor. A Provider may not file a grievance or an appeal on behalf of a Member without written designation by the Member as the Member's representative. A Provider shall have the right to file an appeal with the Contractor regarding provider payment or contractual issues.	claims issues that providers are encouraged to pursue before filing grievances or appeals. These are documented as an "inquiry" in Navigator. The plan indicated onsite that some grievances and appeals may actually be inquiries, although identified as grievances or appeals. A provider's right to file a grievance or appeal is noted in the Provider Manual and Provider grievances are described in member grievance policy APP-004, and examples include perceived lack of helpfulness of Customer Service representatives and timeliness of claim payment. P/P APP-003 defines a grievance as an expression of dissatisfaction with policies, procedures or any aspect of health plan functions. <u>Grievance File Review</u> While some provider grievances were on behalf of members and some were claims-related, it appeared that there was some confusion between provider grievances and inquiries among the provider grievance files. In one file the provider was calling to complain about Provider Relations not returning phone calls; a sticky note on file indicates that this was not		appeals files and 5 provider grievance files were reviewed. All files were classified correctly and were clear with regard to whether it was an appeal or grievance and whether member or provider. All files were resolved timely. None of the files required an extension.	

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	handled as a complaint. Another case, whose call about a member may not have been a complaint, included a notation that providers do not have a grievance option. The documentation in the file for another member was not clear, although a sticky note indicates that it is not a complaint. As per P/P AAP-003, grievances are acknowledged within five working days for pre-service issues. Appeals are to be acknowledged within 5 working days as per APP-003 and resolved within 30 calendar days with written notice provided.APP-003 does not reference resolution of provider grievances within30 days, although the Provider Manual does, and APP-004 appears to reference resolution of both member and provider grievances within 30 days. As noted above, 9/10 provider appeals received acknowledgement within 5 days. Only 3/15 provider grievances received an acknowledgement letter, including 2/3 that were member grievances, and one other provider grievance regarding a denial and lack of a return call from Provider Relations.			

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	6/15 files in the provider grievance sample included documentation that they were resolved in 30 days. • 8/15 grievance files did not include a clear date of resolution. • 1/15 provider complaints was resolved in 34 days. • 9/10 provider appeals were documented as resolved within 30 days. There is no reference to fourteen day extension policy in APP-003, although it appears in the Provider Manual for grievances and in member appeal policy APP-002. A sample extension letter for provider appeals KYGA00013 informs the provider that more time is needed for the appeal, but does not request the extension from the provider. P/P APP-003 includes written authorization for appeals to be filed on behalf of members. Written consent for filing appeals for members is included in P/Ps APP-002 and APP-003 and is in the Provider Manual. All provider appeals filed on behalf of a member included consent in the files. **MCO Response:** CoventryCares of			

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	Kentucky has made many improvements to the Grievance System in 2013. Improvements include: See Above.			
27. 9 Other Related Processes				
The Contractor shall provide information specified in 42 CFR 438.10(g)(1) about the grievance system to all service providers and subcontractors at the time they enter into a contract.				
All grievance or appeal files shall be maintained in a secure and designated area and be accessible to the Department or its designee, upon request, for review. Grievance or appeal files shall be retained for ten (10) years following the final decision by the Contractor, HSD, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.				
The Contractor shall have procedures for assuring that files contain sufficient information to identify the grievance or appeal, the date it was received, the nature of the grievance or appeal, notice to the Member of receipt of the grievance or appeal, all correspondence between the Contractor and the Member, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the Member, and all other pertinent information.				
Documentation regarding the grievance shall be made available to the Member, if requested.				

Grievance System

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	22	4	2	0
Total Points	66	8	2	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.71**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Grievance System
Suggested Evidence

Documents

Policies/procedures for:

- Grievances including handling of quality-related cases
- Appeals
- State hearings

QI Committee minutes or other documentation demonstrating investigation, evaluation, analysis and follow-up of aggregated grievance and appeal data

Process for quality oversight of grievance processing

Evidence of quality oversight and follow-up for grievance processing

Reports

Quarterly reports of grievances and appeals

File Review

Member and Provider grievance files for a sample of files selected by EQRO

Member and Provider appeal files for a sample of files selected by EQRO

QI Committee minutes or other documentation demonstrating investigation and any action taken for individual grievance and appeal files selected for review by the EQRO

CoventryCares of Kentucky (CCKY)
Health Risk Assessment (2014)

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Health Risk Assessment *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
34.1 Health Risk Assessment				
The Contractor shall have programs and processes in place to address the preventive and chronic healthcare needs of its population. The Contractor shall implement processes to assess, monitor, and evaluate services to all subpopulations, including but not limited to, the on-going special conditions that require a course of treatment or regular care monitoring, Medicaid eligibility category, type of disability or chronic conditions, race, ethnicity, gender and age.				
The Contractor shall conduct initial health screening assessment of new Members who have not been enrolled in the prior twelve (12) month period, for the purpose of assessing the Member's need for any special health care needs within ninety (90) days of Enrollment. Members whose Contractor has a reasonable belief to be pregnant shall be screened within thirty (30) days of Enrollment, and if pregnant, referred for appropriate prenatal care.	Minimal - P/P CM-022 documents health screening assessment for new members within 90 days and within 30 days of enrollment for pregnant members. Assessment tools were provided that provide evidence of assessment of members' needs (Medicaid Regulatory Assessment, Good Health Profiles). HRA File Review The plan provided only 3/50 files for review, so it could not be ascertained how frequently timely health screening was conducted. Of the 3 files provided with completed Health Risk Assessments (HRAs), one did not provide a clear date of completion so it is unclear when it was completed. The others were completed	Minimal	P/P CM 022 Health Risk Assessment Member Participation describes the process and procedure for health risk screening for special needs of new members within 90 days of enrollment and 30 days for members believed to be pregnant, who if pregnant will be referred. P/P CM 021 Health Risk Assessment outlines the outreach procedure for health risk assessment that is conducted by the plan's contracted vendor, which includes at least three outreach attempts on three different days and both telephonic and mailed outreach. As noted by the plan in response to last year's findings, this	The Kentucky Spirit Health Plan exited the Kentucky Medicaid managed care market suddenly in July 2013. All former KSHP members were assigned an effective date with their new MCO of July 6, 2013. As a result, CoventryCares of Kentucky could not determine if KSHP had performed a health risk assessment for the member. To ensure that members were provided a smooth transition to CoventryCares in light of their former MCO's sudden exit, CoventryCares elected to reach out to each former KSHP member with a welcome call. During the welcome call members were asked questions about their health care needs and if

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	timely. **MCO Response:** CoventryCares of Kentucky handles the Medicaid Regulatory assessment in-house and not as a portion of the Health Risk Assessment (HRA) contracted to NRC. NRC Good Health Profile is a screening tool that assists in stratifying a Member's risks and appropriateness for case management. The Medicaid Regulatory assessment is completed by a CoventryCares of Kentucky case manager within 30 days of member enrollment into case management. The NRC Good Health Profile assessment completion date is listed in the enclosed spreadsheet for member as noted in your findings. Through the EQRO response process, CoventryCares of Kentucky identified the file extract sent to NRC was flawed. Members, who became eligible after the extract was sent on the 8th of each month, were not sent to NRC. The extract has been corrected. CoventryCares of Kentucky has asked NRC to review all the members affected by the erroneous file extract and to perform and HRA if the (member is still Medicaid eligible and a Coventry member.		assessment is a screening to assist in stratifying members' risks and the plan improved the process by which new member files are provided to the vendor by the plan. The vendor process for outreach is described in the vendor's NRC Health Risk Assessment Data Collection policy that the plan provided. HRA data are included as a data source for member identification for case management for members with special health care needs (P/P CM-017) and complex case management (P/P CM-004). <u>HRA File Review</u> The plan did not provide any files for review of the 25 members in the sample. It could not be ascertained how frequently timely health screening was conducted. Documentation was received in the form of a call log for 11 members. 5 had at least 3 attempts. 1 had a hang up. 6 had outbound consent which meant that an automated questionnaire was performed. Samples of the HRA were provided. Only attempts to contact member are by phone. 3 members were enrolled prior to auth date and CCKY will look at the logic.	the member's response triggered a risk, the member was transferred to a nurse who completed a health risk assessment for the member. Members identified as needing immediate care, as pregnant, or with a chronic condition, were referred to the case management team for immediate outreach. When IPro pulled the universe of new members for CoventryCares, the majority of the "new" members were former KSHP members. The former KSHP membership should have been excluded from the universe as the obligation to complete a HRA is that of the member's first MCO – in this case, KSHP. As a result of the overly broad universe, the sample selected skewed to select members from the former KSHP membership instead of members who should receive an HRA under the contract terms (new to Medicaid eligibility within the past twelve months and pregnant members). As a result, the members selected as part of the sample may not have an HRA completed by

Health Risk Assessment *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			NOTE: CCKY stated that only "new" members to Medicaid are required to receive an HRA and that the majority of the members in the sample were existing members from KY Spirit. **Recommendation for CCKY** All members new to CCKY should receive an HRA. Outreach attempts for completion of an HRA should be documented and made available for EQRO review.	CoventryCares as we were not obligated under the contract to perform an HRA for the former KSHP membership. Where an HRA was completed for one of these members, it was where CoventryCares exceeded the contractual requirements to ensure former KSHP members were not harmed by the sudden exit of their MCO. CoventryCares provided the auditors copies of the outgoing call logs to indicate the attempts at welcome call to the former KSHP membership. This explanation was given to the on-site auditors on multiple occasions. A new universe excluding the former KSHP members should have been generated or credit provided for the extra efforts undertaken by CoventryCares of Kentucky. However, the auditors have erroneously identified this as an area for which the plan was not fully compliant. CoventryCares of Kentucky respectfully disagrees with this finding and request this finding be rescinded.

Health Risk Assessment *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor agrees to make all reasonable efforts to contact new Members in person, by telephone, or by mail to have Members complete the initial health screening questionnaire.	Minimal - P/P CM-022 includes making reasonable efforts to contact members. As per policy CM-021, the plan's contracted vendor conducts three calls at three different times on three different days; if still unable to reach the member, a letter is sent to the member to call the vendor on a toll free number. The HRA will be completed on the phone or mailed if requested. A detailed process for contacts is outlined in the document National Research Corporation Health Risk Assessment Data Collection Policy. Although by policy completed HRAs are given to the plan for review, only 3/50 requested files were provided to the IPRO reviewer. For one of the files, there is documentation of multiple attempts at calls and letters between 11/29/12 and 1/14/13 until the HRA was completed on an unclear date. The other two files were completed timely. It could not be ascertained how many attempts were made for the 47 files not provided for review. **MCO Response:** As mentioned above, the 47/50 files without contact activity were the result of a flawed identification process. Members who are correctly identified and transmitted to NRC will have contact	Minimal	P/P CM 022 includes reasonable efforts to contact members as per contract language. The process is described in P/P CM 021 and also in the vendor's NRC Health Risk Assessment Data Collection policy. At the onsite CCKY mentioned that they do not outreach in person. The plan did not provide any files for review of the 25 members in the sample. It could not be ascertained how frequently timely health screening was conducted. Documentation was received in the form of a call log for 11 members. 5 had at least 3 attempts. 1 had a hang up. 6 had outbound consent which meant that an automated questionnaire was performed. Samples of the HRA were provided. Only attempts to contact member are by phone. NOTE: CCKY stated that only "new" members to Medicaid are required to receive an HRA and that the majority of the members on the sample were existing members from KY Spirit. **Recommendation for CCKY** All members new to CCKY should	The Kentucky Spirit Health Plan exited the Kentucky Medicaid managed care market suddenly in July 2013. All former KSHP members were assigned an effective date with their new MCO of July 6, 2013. As a result, CoventryCares of Kentucky could not determine if KSHP had performed a health risk assessment for the member. To ensure that members were provided a smooth transition to CoventryCares in light of their former MCO's sudden exit, CoventryCares elected to reach out to each former KSHP member with a welcome call. During the welcome call members were asked questions about their health care needs and if the member's response triggered a risk, the member was transferred to a nurse who completed a health risk assessment for the member. Members identified as needing immediate care, as pregnant, or with a chronic condition, were referred to the case management team for immediate outreach. When iPro pulled the universe of new members for CoventryCares, the majority of the "new" members were

Health Risk Assessment (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	activity that is demonstrated in the enclosed spreadsheet (NRC Member Contact Activity).		receive an HRA. Outreach attempts for completion of an HRA should be documented and made available for EQRO review.	former KSHP members. The former KSHP membership should have been excluded from the universe as the obligation to complete a HRA is that of the member's first MCO – in this case, KSHP. As a result of the overly broad universe, the sample selected skewed to select members from the former KSHP membership instead of members who should receive an HRA under the contract terms (new to Medicaid eligibility within the past twelve months and pregnant members). As a result, the members selected as part of the sample may not have an HRA completed by CoventryCares as we were not obligated under the contract to perform an HRA for the former KSHP membership. Where an HRA was completed for one of these members, it was where CoventryCares exceeded the contractual requirements to ensure former KSHP members were not harmed by the sudden exit of their MCO. CoventryCares provided the auditors copies of the outgoing call logs to indicate the attempts at

Health Risk Assessment (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				welcome call to the former KSHP membership. This explanation was given to the on-site auditors on multiple occasions. A new universe excluding the former KSHP members should have been generated or credit provided for the extra efforts undertaken by CoventryCares of Kentucky. However, the auditors have erroneously identified this as an area for which the plan was not fully compliant. CoventryCares of Kentucky respectfully disagrees with this finding and request this finding be rescinded.
Information to be collected shall include demographic information, current health and behavioral health status to determine the Member's need for care management, disease management, behavioral health services and/ or any other health or community services.	Substantial - P/P CM-022 indicates that this information should be included in Health Risk Assessments, and the tools used to collect HRA information contain these elements, including the Medicaid Regulatory Assessment. Of the three completed HRAs submitted, 2/3 included demographic information. 3/3 files included current health and behavioral status to determine need for care management, disease management, behavioral or other health services. **Recommendation for Coventry Cares**	Minimal	P/P CM 022 includes this information to be collected (need for care management, disease management, behavioral health services and/or other health/community services. The Good Health Profiles questionnaire (initial screening) includes current health status, demographics, medications, chronic conditions including behavioral conditions, and behavioral risks. The plan provided a template Child Health Screening Tool that addresses all required areas in detail, and a Maternity Health Profiles that is also	The Kentucky Spirit Health Plan exited the Kentucky Medicaid managed care market suddenly in July 2013. All former KSHP members were assigned an effective date with their new MCO of July 6, 2013. As a result, CoventryCares of Kentucky could not determine if KSHP had performed a health risk assessment for the member. To ensure that members were provided a smooth transition to CoventryCares in light of their former MCO's sudden exit, CoventryCares elected to reach out

Health Risk Assessment *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	HRA files should include demographic information.		very detailed and targeted to obstetric risks. These two documents include detailed demographic information. The plan did not provide any files for review of the 25 members in the sample. It could not be ascertained whether demographic information would be included. **Recommendation for CCKY** All members new to CCKY should receive an HRA. Outreach attempts for completion of an HRA should be documented and made available for EQRO review.	to each former KSHP member with a welcome call. During the welcome call members were asked questions about their health care needs and if the member's response triggered a risk, the member was transferred to a nurse who completed a health risk assessment for the member. Members identified as needing immediate care, as pregnant, or with a chronic condition, were referred to the case management team for immediate outreach. When iPro pulled the universe of new members for CoventryCares, the majority of the "new" members were former KSHP members. The former KSHP membership should have been excluded from the universe as the obligation to complete a HRA is that of the member's first MCO – in this case, KSHP. As a result of the overly broad universe, the sample selected skewed to select members from the former KSHP membership instead of members who should receive an HRA under the contract terms (new to Medicaid eligibility within the past

Health Risk Assessment *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				twelve months and pregnant members). As a result, the members selected as part of the sample may not have an HRA completed by CoventryCares as we were not obligated under the contract to perform an HRA for the former KSHP membership. Where an HRA was completed for one of these members, it was where CoventryCares exceeded the contractual requirements to ensure former KSHP members were not harmed by the sudden exit of their MCO. CoventryCares provided the auditors copies of the outgoing call logs to indicate the attempts at welcome call to the former KSHP membership. This explanation was given to the on-site auditors on multiple occasions. A new universe excluding the former KSHP members should have been generated or credit provided for the extra efforts undertaken by CoventryCares of Kentucky. However, the auditors have erroneously identified this as an area for which the plan was not fully compliant. CoventryCares of

Health Risk Assessment *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				Kentucky respectfully disagrees with this finding and request this finding be rescinded.
The Contractor shall use appropriate healthcare professionals in the assessment process.				
Members shall be offered assistance in arranging an initial visit to their PCP for a baseline medical assessment and other preventative services, including an assessment or screening of the Members potential risk, if any, for specific diseases or conditions.	Substantial - As per P/P CM-022, members are encouraged to contact their PCP and schedule a PCP visit. Assisting the member with an appointment is not specifically referenced. Of the 3 completed HRAs submitted for review, 0/3 required assistance with a PCP appointment, as they had either already had an appointment or had one scheduled. **Recommendation for Coventry Cares** The MCO should ensure that members are offered assistance by policy if unable to schedule on their own.	Full	P/P CM 022 includes description of HRA as a participatory process, and notes that members are encouraged to contact their PCP and schedule an appointment upon completion of the HRA, as well as develop a personal health plan. Language has been added to P/P CM 022 that indicates that members identified as high risk that require assistance in setting up an appointment will be assisted by the case manager.	
The Contractor shall submit a quarterly report on the number of new Member assessments; number of assessments completed; number of assessments not completed after reasonable effort; number of refusals.				

Health Risk Assessment

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	1	0	3	0
Total Points	3	0	3	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average			**1.5**	

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Health Risk Assessment
Suggested Evidence

Documents

Policies/procedures for:

- Initial health screening assessment (including initial health screening tool)

File Review

File review of a sample of cases selected by the EQRO

Reports

Quarterly reports on the number of new member assessments; number of assessments completed; number of assessments not completed after reasonable effort; number of refusals
Evidence of monitoring of health screening assessment completion rates, and follow-up actions to increase completion rates

CoventryCares of Kentucky (CCKY)
Structure and Operations – Credentialing (2014)

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Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
27.2 Provider Credentialing and Recredentialing				
In compliance with 907 KAR 1:672 and federal law, the Contractor shall document the procedure, which shall comply with the Department's current policies and procedures, for credentialing and recredentialing of providers with whom it contracts or employs to treat members. This documentation shall include, but not be limited to,				
defining the scope of providers covered,				
the criteria and the primary source verification of information used to meet the criteria,				
the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements.				
The contractor shall have a process for receiving input from participating providers regarding credentialing and recredentialling of providers.				
Those providers accountable to a formal governing body for review of credentials shall include physicians; dentists, advanced registered nurse practitioners, audiologist, CRNA, optometrist, podiatrist, chiropractor, physician assistant, and other licensed or certified practitioners.				
Providers required to be recredentialed by the Contractor per Department policy are physicians, audiologists, certified registered nurse anesthetists, advanced registered nurse				

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
practitioners, podiatrists, chiropractors and physician assistants. However, if any of these providers are hospital-based, credentialing will be performed by the Department.				
The contractor shall be responsible for the ongoing review of provider performance and credentialing as specified below:				
A. The contractor shall verify that its enrolled network Providers to whom members may be referred are properly licensed in accordance with all applicable Commonwealth law and regulations, and have in effect such current policies of malpractice insurance as may be required by the Contractor.				
B. The process for verification of Provider credentials and insurance, and any additional facts for further verification and periodic review of Provider performance, shall be embodied in written policies and procedures, approved in writing by the Department.				
C. The Contractor shall maintain a file for each Provider containing a copy of the Provider's current license issued by the Commonwealth and such additional information as may be specified by the Department.				
D. The process for verification of Provider credentials and insurance shall be in conformance with the Department's policies and procedures. The Contractor shall meet requirements under KRS 295.560 (12) related to credentialing. The				

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determinatio n**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Contractor's enrolled providers shall complete a credentialing application in accordance with the Department's policies and procedures.				
The process for verification of Provider credentials and insurance shall include the following:				
A. Written policies and procedures that include the Contractor's initial process for credentialing as well as its re-credentialing process that must occur, at a minimum, every three (3) years;				
B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;				
C. A review of the credentialing policies and procedures by the formal body;				
D. A credentialing committee which makes recommendations regarding credentialing;				
E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;				
F. Written procedures for the termination or suspension of Providers; and				
G. Written procedures for, and the implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider.				
The contractor shall meet requirements under KRS 205.560(12) related to credentialing.	Substantial - P/P CP - 001 addresses this requirement. CVC Policy and	Substantial	P/P CP – 001 Provider Types, Requirement, Rights address this	Effective 7/21/2014, hiring of a SR Credentialing Analyst onsite at the

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Verification of the Providers credentials shall include the following:	Procedures also addresses this requirement. During the onsite review, IPRO reviewed 10 PCP credentialing files and 10 Specialist credentialing files with the following results: PCP Files: 1 PCP – Unable to determine hospital privileges. 2 PCPs – No evidence of hospital affiliations. 1 PCP – Out of state License (no license in KY). Specialist Files: 1 Specialist – Not a specialist – an Internal Medicine physician with no secondary specialty. 1 Specialist – unable to determine board certification. 1 Specialist – out of state license (no license in KY). Overall, although information was presented, the files were inconsistently organized. Coventry Cares advised during the onsite review that the Credentialing Committee will be		requirement. Credentialing File Review IPRO reviewed 10 PCP credentialing files and 10 Specialist credentialing files with the following results: PCP Files 10/10 files reviewed were fully compliant. Specialist Files 8/10 files were compliant. 1 specialist – Recredentialed after 3 years 2 months. 1 specialist – No signed attestation. No evidence of credentialing. MCO states that facility conducts credentialing for this specialist. Overall, although information was presented, the files were inconsistently organized. Provider information was stored in both the Corporate and MCO systems which prevents the MCO from maintaining one complete, consistent provider file. **Recommendation for CCKY** Files provided should include complete most up to date information. The MCO should include copies of the most recently signed attestation with the provider files.	Health Plan will provide resolution moving forward. Responsibilities of this role will include verification of all provider credentials, ongoing monitoring and managing of provider credentialing files in accordance with P/P CP- 001 Provider Types, Requirement, and Rights.

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	located locally in Kentucky beginning April 2013. **Recommendation for Coventry Cares** Files provided should include complete information. The MCO should include a provider profile in the physician's chart. A provider profile aids the MCO during the recredentialing period regarding over/under utilization and grievances from members.			
A. A current valid license or certificate to practice in the Commonwealth of Kentucky.				
B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;				
C. Primary source of graduation from medical school and completion of an appropriate residency, or accredited nursing, dental, physician assistant or vision program, as applicable; if provider is not Board Certified.				
D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;				
E. Professional board certification, eligibility for certification, or graduation from a training program to serve children with special health care needs under twenty-one (21) years of age;				

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
F. Previous five (5) years work history;				
G. Professional liability claims history;				
H. Clinical privileges and performance in good standing at the hospital designated by the Provider as the primary admitting facility, for all providers whose practice requires access to a hospital, as verified through attestation;				
I. Current, adequate malpractice insurance, as verified through attestation;				
J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;				
K. Documentation of curtailment or suspension of medical staff privileges;				
L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;				
M. Documentation of censure by the State or County professional association; and				
N. Most recent information available from the National Practitioner Data Bank.				
The provider shall complete a credentialing application that includes a statement by the applicant regarding:				
A. The ability to perform essential functions of the positions, with or without accommodation;				

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determinatio n**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. Lack of present illegal drug use;				
C. History of loss of license and felony convictions;				
D. History of loss or limitation of privileges or disciplinary activity;				
E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and				
F. Applicant attests to correctness and completeness of the application				
Before a practitioner is credentialed, the Contractor shall verify information from the following organizations and shall include the information in the credentialing files:				
A. National practitioner data bank, if applicable;				
B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and				
C. Other recognized monitoring organizations appropriate to the practitioner's discipline.				
At the time of credentialing, the Contractor shall perform an initial visit to potential providers, as it deems necessary and/or as required by law.				
The Contractor shall document a structured review to evaluate the site against the Contractor's organizational standards and those specified by this contract.				

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall document an evaluation of the medical record documentation and keeping practices at each site for conformity with the Contractors organizational standards and this contract.				
The Contractor shall have formalized recredentialing procedures. The Contractor shall formally recredential its providers at least every three (3) years. The Contractor shall comply with the Department's recredentialing policies and procedures. There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from:				
A. A current license to practice;				
B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;				
C. A valid DEA, if applicable;				
D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialed;				
E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and				
F. A current signed attestation statement by the applicant regarding:				

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
1. The ability to perform the essential functions of the position, with or without accommodation;				
2. The lack of current illegal drug use;				
3. A history of loss, limitation of privileges or any disciplinary action; and				
4. Current malpractice insurance.				
There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from :				
A. The national practitioner data bank;				
B. Medicare and Medicaid;				
C. State boards of practice, as applicable; and				
D. Other recognized monitoring organizations appropriate to the practitioner's specialty.				
The Contractor will use the format provided in Appendix H to transmit the listed provider credentialing elements to the Department. A Credentialing Process Coversheet will be generated per provider. The Credentialing Process Coversheet will be submitted electronically to the Department's fiscal agent.				
The Contractor shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take				

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determinatio n**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
appropriate action.				
The Contractor shall have written policies and procedures for the initial and on-going assessment of organizational providers with whom it intends to contract or which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, free-standing surgical centers, residential treatment centers and clinics.				
At least every three (3) years, the Contractor shall confirm the provider is in good standing with state and federal regulating bodies, including the Department, and, has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by the Contractor.				
The Contractor shall have policies and procedures for altering conditions of the practitioners participation with the Contractor based on issues of quality of care and services.				
The Contractor shall have procedures for reporting to the appropriate authorities, including the Department, serious quality deficiencies that could result in a practitioner's suspension or termination.				
If a provider requires review by the Contractor's credentialing Committee, based on the Contractor's quality criteria, the Contractor will notify the Department regarding the facts and outcomes of the review in support of the State				

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Medicaid credentialing process.				
The Contractor shall use the provider types summaries listed at: http://chfs.ky.gov/dms/provEnr/Provider+Types.htm				
28.1 Network Providers to be Enrolled				
The Contractor's Network shall include Providers from throughout the provider community. The Contractor shall comply with the any willing provider statute as described in 907 KAR 1:672 and KRS 304.17A-270. Neither the Contractor nor any of its Subcontractors shall require a Provider to enroll exclusively with its network to provide Covered Services under this Contract as such would violate the requirement of 42 CFR Part 438 to provide Members with continuity of care and choice. The Contractor shall enroll at least one (1) Federally Qualified Health Center (FQHC) into its network if there is a FQHC appropriately licensed to provide services in the region or service area and at least one teaching hospital. In addition the Contractor shall enroll the following types of providers who are willing to meet the terms and conditions for participation established by the Contractor: physicians, advanced practice registered nurses, physician assistants, birthing centers, dentists, primary care centers including, home health agencies, rural health clinics, opticians, optometrists, audiologists, hearing aid vendors, pharmacies, durable medical equipment suppliers, podiatrists, renal dialysis clinics, ambulatory surgical centers, family planning				

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
providers, emergency medical transportation provider, non-emergency medical transportation providers as specified by the Department, other laboratory and x-ray providers, individuals and clinics providing Early and Periodic Screening, Diagnosis, and Treatment services, chiropractors, community mental health centers, psychiatric residential treatment facilities, hospitals (including acute care, critical access, rehabilitation, and psychiatric hospitals), local health departments, and providers of EPSDT Special Services. The Contractor may also enroll other providers, which meet the credentialing requirements, to the extent necessary to provide covered services to the Members. Enrollment forms shall include those used by the Kentucky Medicaid Program as pertains to the provider type. The Contractor shall use such enrollment forms as required by the Department. The Department will continue to enroll and certify hospitals, nursing facilities, home health agencies, independent laboratories, preventive health care providers, and hospices. The Medicaid provider file will be available for review by the Contractor so that the Contractor can ascertain the status of a Provider with the Medicaid Program and the provider number assigned by the Kentucky Medicaid Program.				
Providers performing laboratory tests are required to be certified under the CLIA. The Department will continue to update the provider file with CLIA information from the OSCAR file				

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
provided by the Centers for Medicare and Medicaid Services for all appropriate providers. This will make laboratory certification information available to the Contractor on the Medicaid provider file.				
The Contractor shall have written policies and procedures regarding the selection and retention of the Contractor's Network. The policies and procedures regarding selection and retention must not discriminate against providers who service high-risk populations or who specialize in conditions that require costly treatment or based upon that Provider's licensure or certification.				
If the Contractor declines to include individuals or groups of providers in its network, it shall give affected providers written notice of the reason for its decision.				
The Contractor must offer participation agreements with currently enrolled Medicaid providers who have received electronic health record incentive funds who are willing to meet the terms and conditions for participation established by the Contractor.				
28.2 Out-of-Network Providers				
The Department will provide the Contractor with a streamlined enrollment process to assign provider numbers for Out-of-network providers. Only out-of-network hospitals and physicians are allowed to complete the Registration short form in emergency situations. The Contractor shall, in a				

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
format specified by the Department report all out-of-network utilization by Members.				
28.3 Contractor's Provider Network				
The Contractor may enroll providers in their network who are not participating in the Kentucky Medicaid Program. Providers shall meet the credentialing standards described in Provider Credentialing and Re-Credentialing of this Contract and be eligible to enroll with the Kentucky Medicaid Program. A provider joining the Contractor's Network shall meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type. The Contractor shall provide written notice to Providers not accepted into the network along with the reasons for the non-acceptance. A provider cannot enroll in the Contractor's Network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process. The Contractor shall obtain access to the National Practitioner Database as part of their credentialing process in order to verify the Provider's eligibility for network participation. Federal Financial Participation is not available for				

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for Emergency Medical Services.				
28.4 Enrolling Current Medicaid Providers				
The Contractor will have access to the Department Medicaid provider file either by direct on-line inquiry access, by electronic file transfer, or by means of an extract provided by the Department. The Medicaid provider master file is to be used by the Contractor to obtain the ten-digit provider number assigned to a medical provider by the Department, the Provider's status with the Medicaid program, CLIA certification, and other information. The Contractor shall use the Medicaid Provider number as the provider identifier when transmitting information or communicating about any provider to the Department or its Fiscal Agent The Contractor shall transmit a file of Provider data specified in this Contract for all credentialed Providers in the Contractor's network on a monthly basis and when any information changes.				
28.5 Enrolling New Providers and Providers not Participating in Medicaid				
A medical provider is not required to participate in the Kentucky Medicaid Program as a condition of participation with the Contractor's Network. If a potential Provider has not had a Medicaid number assigned, the Contractor will obtain all data and forms necessary to enroll within the Contractor's Network, and include the required				

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
data in any transmission of the provider file information with the exception of the Medicaid Provider number.				
28.6 Termination of Network Providers or Subcontractors				
Any Provider or Subcontractor who engages in activities that result in suspension, termination, or exclusion from the Medicare or Medicaid program shall be terminated from participation.				
The Department shall notify the Contractor of suspension, termination, and exclusion actions taken against Medicaid providers by the Kentucky Medicaid program within three business days via e-mail. The Department will notify the Contractor of voluntary terminations within five business days via email.				
The Contractor shall notify the Department of suspension, termination, and exclusion from Contractor's network taken against a Provider within three business days via email. The Contractor shall notify the Department of voluntary terminations within five business days via email. The Contractor will provide all terminations monthly, via the Provider Termination Report as referenced in Appendix K. The Contractor shall terminate the Provider effective the same date as the Medicaid program termination.				

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	0	1	0	0
Total Points	0	2	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.0**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable	Statement does not require a review decision

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

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Quality Assessment and Performance Improvement: Structure and Operations – Credentialing
Suggested Evidence

Documents

Policies and Procedures for:

- Enrollment of network providers
- Enrollment of out-of-network providers
- Provider Credentialing and Recredentialing including delegated credentialing
- Monitoring of provider sanctions, complaints and quality issues between recredentialing cycles
- Altering conditions of participation
- Termination/Suspension of providers
- Initial and ongoing assessment of organizational providers

Credentialing Committee description, membership, meeting agendas and minutes

Reports

Reports of oversight of delegated credentialing
Reports to DMS and/or other authorities of serious quality issues that could result in provider suspension or termination
Sample provider file report of provider credentialing for DMS Fiscal Agent
Sample reports to DMS of cases where a provider requires review by the Credentialing Committee

File Review

Sample of Credentialing and Recredentialing files for varied provider types selected by the EQRO

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CoventryCares of Kentucky (CCKY)
Access (2014)

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Quality Assessment and Performance Improvement: Access *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
27.3 Primary Care Provider Responsibilities				
A primary care provider (PCP) is a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse (including a nurse practitioner, nurse midwife and clinical specialist), physician assistant, or clinic (including a FQHC, primary care center and rural health clinic), that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and agrees to provide twenty-four (24) hours per day, seven (7) days a week primary health care services to individuals. Primary care physician residents may function as PCPs. The PCP shall serve as the member's initial and most important point of contact with the Contractor. This role requires a responsibility to both the Contractor and the Member. Although PCPs are given this responsibility, the Contractors shall retain the ultimate responsibility for monitoring PCP actions to ensure they comply with the Contractor and Department policies.				
Specialty providers may serve as PCPs under certain circumstances, depending on the Member's needs. The decision to utilize a specialist as the PCP shall be based on agreement among the Member or family, the specialist, and the Contractor's medical director. The Member has the right to Appeal such a decision in the formal Appeals process.				

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall monitor PCP's actions to ensure he/she complies with the Contractor's and Department's policies including but not limited to the following:				
A. Maintaining continuity of the Member's health care;				
B. Making referrals for specialty care and other Medically Necessary services, both in and out of network, if such services are not available within the Contractor's network;				
C. Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services;				
D. Discussing Advance Medical Directives with all Members as appropriate;				
E. Providing primary and preventative care, recommending or arranging for all necessary preventive health care, including EPSDT for persons under the age of 21 years;				
F. Documenting all care rendered in a complete and accurate medical record that meets or exceeds the Department's specifications; and				
G. Arranging and referring members when clinically appropriate, to behavioral health providers				
Maintaining formalized relationships with other PCPs to refer their Members for after hours care, during certain days, for certain services, or other reasons to extend their practice. The PCP remains solely responsible for the PCP functions (A) through				

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(G) above.				
The Contractor shall ensure that the following acceptable after-hours phone arrangements are implemented by PCPs in Contractor's Network and that the unacceptable arrangements are not implemented:				
A. Acceptable				
(1) Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of thirty (30) minutes;				
(2) Office phone is answered after hours by a recording directing the Member to call another number to reach the PCP or another medical practitioner whom the Provider has designated to return the call within a maximum of thirty (30) minutes; and				
(3) Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of thirty (30) minutes.				
B. Unacceptable				
(1) Office phone is only answered during office hours;				
(2) Office phone is answered after hours by a recording that tells Members to leave a message;				

Quality Assessment and Performance Improvement: Access *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(3) Office phone is answered after hours by a recording that directs Members to go to the emergency room for any services needed; and				
(4) Returning after-hours calls outside of thirty (30) minutes.				
28.7 Provider Program Capacity Demonstration				
The Contractor shall assure that all Covered Services are as accessible to Members (in terms of timeliness, amount, duration, and scope) as the same services as are available to commercial insurance members in the Contractor's Region; and that no incentive is provided, monetary or otherwise, to providers for the withholding from Members of Medically Necessary services.				
The Contractor shall make available and accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section.				
Emergency medical services shall be made available to Members twenty-four (24) hours a day, seven (7) days a week. Urgent care services by any provider in the Contractor's Program shall be made available within 48 hours of request. The Contractor shall provide the following:				
A. Primary Care Provider (PCP) delivery sites that are: no more than thirty (30) miles or thirty (30) minutes from Members in urban areas, and for Members in non-urban areas, no more than forty-five (45) minutes or forty-five (45) miles from Member residence; with a member to PCP (FTE)				

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
ratio not to exceed 1500:1; and with appointment and waiting times, not to exceed thirty (30) days from date of a Member's request for routine and preventive services and forty-eight (48) hours for Urgent Care.				
B. Specialty care in which referral appointments to specialists shall not exceed thirty (30) days for routine care or forty-eight (48) hours for Urgent Care; except for Behavioral Health Services for which emergency care with crisis stabilization must be provided within twenty-four (24) hours, urgent care which must be provided within forty-eight (48) hours, services may not exceed fourteen (14) days post discharge from an acute Psychiatric Hospital and sixty (60) days for other referrals. Specialists shall be commensurate with the subpopulations designated by the Department, and include sufficient pediatric specialists to meet the needs of Members younger than twenty-one (21) years of age.	Minimal - Addressed in P/Ps PR 006, Accessing Appointment Availability and PR – 002, Provider Accessibility and Availability. Evidence of monitoring provider compliance with hours of operation, including after-hours availability was not available. Geo Access reports were provided and are discussed below. **MCO Response:** Coventry Cares has instituted a "Secret Shopper" program, overseen by our regional Vice President of Quality Improvement. Among other things, the "Secret Shopper" program randomly checks on providers to ensure minimum accessibility requirements are met. The first Secret Shopper	Full	PR 006, Accessing Appointment Availability addresses specialty care appointments not to exceed 30 days, 48 hours for urgent care and BH services for emergency care with stabilization within 24 hours. MHNet Utilization Improvement Manual chapters 4 and 6 were provided to show adherence to Behavioral Health services. A copy of the Mental Health Associates practitioner agreement was also provided. Per CCKY Report #16, Summary of QI Activities, the Secret Shopper survey was completed in Q3 2013. Results were submitted to and discussed by the EIC in December 2013 and an internal CCKY corrective action plan developed.	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	cycle was completed in-house. Based on the results, the plan has contracted with CareCall to perform a follow-up access and availability survey before the close of third quarter 2013.			
C. Immediate treatment for Emergency Care at a health facility that is most suitable for the type of injury, illness or condition, regardless of whether the facility is in Contractor's Network.				
D. Hospital care for which transport time shall not exceed thirty (30) minutes, except in non-urban areas where access time may not exceed sixty (60) minutes, with the exception of Behavioral Health				

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Services and physical rehabilitative services where access shall not exceed sixty (60) minutes.				
E. General dental services for which transport time shall not exceed one (1) hour. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed three (3) weeks for regular appointments and forty eight (48) hours for urgent care.				
F. General vision, laboratory and radiology services for which transport time shall not exceed one (1) hour. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed thirty (30) days for regular appointments and forty eight (48) hours for Urgent Care.				
G. For Pharmacy services, travel time shall not exceed one (1) hour or the delivery site shall not be further than fifty (50) miles from the Member's residence. The Contractor is not required to provide transportation services to Pharmacy services.				
The Contractor shall attempt to enroll the following Providers in its network as follows:				
A. Teaching hospitals;				
B. FQHCs and rural health clinics;				
C. The Kentucky Commission for Children with Special Health Care Needs; and				
D. Community Mental Health Centers				
If the Contractor is not able to reach agreement on	Non-Compliance -	Full	Policy ND-001 states that the Department	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
terms and conditions with these specified providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in this Contract shall be provided to meet the needs of its Members without contracting with these specified providers.	Documents provided do not include the requirement for advising the Department if agreements are not established with the providers listed above. **MCO Response:** Coventry Cares of Kentucky currently has contracts with all teaching hospitals and FQHCs located in Kentucky and with the Kentucky Commission for Children with Special Health Care Needs. In addition, Coventry Cares of Kentucky has a contractual relationship with all Community Mental Health Centers through its subcontractor, MHNet. Also, all RHCs have been recruited and the majority are participating with Coventry Cares of Kentucky. Coventry Cares will revise its Policies and Procedures to include provisions for advising the Department if at any time any of these providers are not contracted.		will be notified if agreements are not established for the four provider types listed above. ND-003 Selection and Retention of Network addresses this requirement.	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Policy ND-001 has been updated to state that the Department will be notified if agreements are not established for the four provider types listed above.			
In consideration of the role that Department for Public Health, which contracts with the local health departments play in promoting population health of the provision of safety net services, the Contractor shall offer a participation agreement to public health departments. Such participation agreements shall include the following provisions:				
A. Coverage of the Preventive Health Package pursuant to 907 KAR 1:360.				
B. Provide reimbursement at rates commensurate with those provided under Medicare.				
The Contractor may also include any charitable providers which serve Members in the Contractor Region, provided that such providers meet credentialing standards.	Non-Compliance - P/Ps PR-002 and ND-002 do not address this requirement. **MCO Response:** Policy and Procedures will be modified to note that charitable providers are eligible for inclusion in the Coventry Cares of KY Network if credentialing standards are met.	Full	Policy and Procedures ND 003 notes that charitable providers are eligible for inclusion in the CCKY Network if credentialing standards are met.	
The Contractor shall demonstrate the extent to	Substantial -	Full	Policy ND-001 has been provided to	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
which it has included providers who have traditionally provided a significant level of care to Medicaid Members. The Contractor shall have participating providers of sufficient types, numbers, and specialties in the service area to assure quality and access to health care services as required for the Quality Improvement program as outlined in Management Information Systems. If the Contractor is unable to contract with these providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in the Contract shall be available to meet the needs of its Members.	Policies/procedures provided do not address this requirement. **MCO Response:** Policy ND-001 has been updated to reflect this requirement. However, CoventryCares has met this requirement by providing regular provider files to the Department for Medicaid Services which the Department reviews for access requirements. Additionally, the Department reviewed the network during readiness review in October and November 2011 and again in December 2012. CoventryCares has met this requirement by providing regular provider files to the Department for Medicaid Services which the Department reviews for access requirements Coventry Cares of Kentucky recruited key providers immediately after being awarded the Medicaid Managed Care contract.		address this requirement. The plan added language to the policy to address reporting to DMS. In response to inquiry, the plan submitted ND-003 which states the plan will make its best attempt to include in its network providers who have traditionally provided a significant level of care to Medicaid Members. Report 80 Provider Change in Network reviewed. Report notes panel size, changes, accepting new members. PR-007 Provider Recruitment Network Shortage Policy states the health plan will notify the Kentucky Department of Medicaid Services of deficiencies and submit a corrective action plan to remedy the area of non-compliance.	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Contracts were pursued based on priorities set through review of previous Medicaid utilization to identify and target providers with high utilization for initial recruitment. CoventryCares has contracted with all but nine general acute care hospitals in Kentucky and the major out of state hospitals that have experienced significant KY Medicaid utilization (Vanderbilt, Cabell-Huntington, University of Cincinnati, The Christ Hospital, and Deaconess Healthcare). Additionally, CoventryCares has contracted with 100% of the FQHCs. CoventryCares of Kentucky has not experienced out of network utilization that we were not able to address and assure member access when appropriate. Finally, Coventry Cares of Kentucky provides regular GeoAccess reports to the			

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Commonwealth to track the availability of all services in the network, in compliance with established Commonwealth of Kentucky guidelines on provider accessibility, by specialty. **IPRO Comments:** Review determination changed to Substantial. Compliance demonstrated in GEO Access reports. P/P updated.			
28.8 Program Mapping				
The Contractor shall initially submit a series of maps and charts in a format prescribed by the Department that describes the Contractor's Provider Network, as set forth below. The use of computer-generated maps is preferred. Maps shall include geographic detail including highways, major streets and the boundaries of the Contractor's network. In addition to the maps and charts, the Contractor shall provide an analysis of the capacity to serve all categories of Members. The analysis shall address the standards for access to care.				
Maps shall include the location of all categories of Providers or provider sites as follows:				
A. Primary Care Providers (designated by a "P")				

Quality Assessment and Performance Improvement: Access *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. Primary Care Centers, non FQHC and RHC (designated by a "C")				
C. Dentists (designated by a "D")				
D. Other Specialty Providers (designated by a "S")				
E. Non-Physician Providers - including nurse practitioners, (designated by a "N") nurse mid-wives (designated by a "M") and physician assistants (designated by a "A")				
F. Hospitals (designated by a "H")				
G. After hours Urgent Care Centers (designated by a "U")				
H. Local health departments (designated by a "L")				
I. Federally Qualified Health Centers/Rural Health Clinics (designated by a "F" or "R" respectively)				
J. Pharmacies (designated by a "X")				
K. Family Planning Clinics (designated by an "Z")				
L. Significant traditional Providers (designated by an "*")				
M. Maternity Care Physicians (designated by a "º")				
N. Vision Providers (designated by a "V")				
O. Community Mental Health Centers (designated by a "M")				
The Contractor shall update these maps to reflect changes in the Contractor's Network on an annual basis, or upon request by the Department.	Substantial - P/P PR – 002 provided, however this policy does not address	Full	PR-002 Provider Access & Availability and ND-002 Availability of Practitioners address this requirement.	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	updates. **Recommendation for Coventry Cares** It is recommended that the MCO update the policy to include this requirement.			
28.9 Expansion and/or Changes in the Network				
If at any time, the Contractor determines that its Contractor Network is not adequate to comply with the access standards specified above, the Contractor shall notify the Department of this situation and submit a corrective action plan to remedy the deficiency. The corrective action plan shall describe the deficiency in detail, including the geographic location and specific regions where the problem exists, and identify specific action steps to be taken by the Contractor and time- frames to correct the deficiency.				
In addition to expanding the service delivery network to remedy access problems, the Contractor shall also make reasonable efforts to recruit additional providers based on Member requests. When Members ask to receive services from a provider not currently enrolled in the network, the Contractor shall contact that provider to determine an interest in enrolling and willingness to meet the Contractor's terms and conditions.				
30.1 Medicaid Covered Services				
The Contractor shall provide, or arrange for the provision of, the Covered Services listed in Appendix				

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
I to Members in accordance with the Contract standards, and according to the Department's regulations, state plan, policies and procedures applicable to each category of Covered Services. The Contractor shall be required to provide Covered Services to the extent services are covered for Members at the time of Enrollment.				
The Contractor shall ensure that the care of new enrollees is not disrupted or interrupted. The Contractor shall ensure continuity of care for new Members receiving health care under fee for service prior to enrollment in the Plan. Appendix I shall serve as a summary of currently Covered Services that the Contractor shall be responsible for providing to Members. However, it is not intended, nor shall it serve as a substitute for the more detailed information relating to Covered Services which is contained in applicable administrative regulations governing Kentucky Medicaid services provision (907 KAR Chapter 1 and 907 KAR 3:005) and individual Medicaid program services manuals incorporated by reference in the administrative regulations.				
After the Execution Date, to the extent a new or expanded Covered Service is added by the Department to Contractor's responsibilities under this Contract, ("New Covered Service") the financial impact of such New Covered Service will be evaluated from an actuarial perspective by the Department, and Capitation Rates to be paid to Contractor hereunder will be adjusted accordingly to 12.2 and 39.16 herein. The determination that a Covered Service is a New Covered Service is at the				

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
discretion of the Department. At least ninety (90) days before the effective date of the addition of a New Covered Service, the Department will provide written notice to Contractor of any such New Covered Service and any adjustment to the Capitation Rates herein as a result of such New Covered Service. This notice shall include: (i) an explanation of the New Covered Service; (ii) the amount of any adjustment to Capitation Rates herein as a result of such New Covered Service; and (iii) the methodology for any such adjustment.				
The Contractor may provide, or arrange to provide, services in addition to the services described in Attachment I, provided quality and access are not diminished, the services are Medically Necessary health services and cost-effective. The cost for these additional services shall not be included in the Capitation Rate. The Contractor shall notify and obtain approval from Department for any new services prior to implementation. The Contractor shall notify the Department by submitting a proposed plan for additional services and specify the level of services in the proposal.				
If coverage of any Medicaid service provided by the Contractor requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be properly completed according to the appropriate Kentucky Administrative Regulation (KAR). The Contractor shall require its Subcontractor or Provider to retain the form in the event of audit and a copy shall be submitted to the Department upon request.				

Quality Assessment and Performance Improvement: Access *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall not prohibit or restrict a Provider from advising a beneficiary about his or her health status, medical care, or treatment, regardless of whether benefits for such care are provided under the Contract, if the Provider is acting within the lawful scope of practice.				
If the Contractor is unable to provide within its network necessary medical services covered under Appendix I, it shall timely and adequately cover these services out of network for the Member for as long as Contractor is unable to provide the services in accordance with 42 CFR 438.206. The Contractor shall coordinate with out-of-network providers with respect to payment. The Contractor will ensure that cost to the Member is no greater than it would be if the services were provided within the Contractor's Network.				
A Member who has received Prior Authorization from the Contractor for referral to a specialist physician or for inpatient care shall be allowed to choose from among all the available specialists and hospitals within the Contractor's Network, to the extent reasonable and appropriate.				
32.3 Emergency Care, Urgent Care and Post Stabilization Care				
Emergency Care shall be available to Members 24 hours a day, seven days a week. Urgent Care services shall be made available within 48 hours of request. Post Stabilization Care services are covered and reimbursed in accordance with 42 CFR 422.113(c) and 438.114(c).				

Quality Assessment and Performance Improvement: Access *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
32.4 Out-of-Network Emergency Care				
The Contractor shall provide, or arrange for the provision of Emergency Care, even though the services may be received outside the Contractor's Network, in accordance with 42 CFR 431.52 and 907 KAR 1:084. These regulations require that the Commonwealth, including Department and its Contractor, cover not only Medically Necessary services due to a medical emergency, but also out-of-state medical services if medical services are needed and the member's health would be endangered if he/she were required to travel to his/her state of residence.				
Payment for Emergency Services covered by a non-contracting provider shall not exceed the Medicaid fee-for service rate as required by Section 6085 of the Deficit Reduction Act of 2005.				
30.2 Direct Access Services				
The Contractor shall make Covered Services available and accessible to Members as specified in Appendix I. The Contractor shall routinely evaluate Out-of-Network utilization and shall contact high volume providers to determine if they are qualified and interested in enrolling in the Contractor's Network. If so, the Contractor shall enroll the provider as soon as the necessary procedures have been completed. When a Member wishes to receive a direct access service or receives a direct access service from an Out-of-Network Provider, the Contractor shall contact the provider to determine if it is qualified and interested in enrolling in the network. If so, the Contractor shall				

Quality Assessment and Performance Improvement: Access *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
enroll the provider as soon as the necessary enrollment procedures have been completed.				
The Contractor shall ensure direct access and may not restrict the choice of a qualified provider by a Member for the following services within the Contractor's network:				
A. Primary care vision services, including the fitting of eye-glasses, provided by ophthalmologists, optometrists and opticians;				
B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;	Substantial - Member Handbook addresses this requirement. **Recommendation for Coventry Cares** It is recommended that oral surgery services and evaluations by orthodontists and prosthodontists be added to P/P UM-O20.	Substantial	This is addressed in the Member Handbook under Direct Access Services. P/P UM-020 does not address oral surgery services and evaluations. **Recommendation for CCKY** As noted last year, oral surgery services and evaluations by orthodontists and prosthodontists should be added to P/P UM-O20.	P/P UM-020 has been updated to include oral surgery services and is on the agenda for the next Policies and Procedures meeting to review and approve.
C. Voluntary family planning in accordance with federal and state laws and judicial opinion;				
D. Maternity care for Members under 18 years of age;				
E. Immunizations to Members under 21 years of age;				
F. Sexually transmitted disease screening, evaluation and treatment;				

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
G. Tuberculosis screening, evaluation and treatment;				
H. Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as defined by 902 KAR 2:020;				
I. Chiropractic services; and				
J. Women's health specialists.				
32.6 Voluntary Family Planning				
The Contractor shall ensure direct access for any Member to a Provider, qualified by experience and training, to provide Family Planning Services, as such services are described in Appendix I to this Contract. The Contractor may not restrict a Member's choice of his or her provider for Family Planning Services. Contractor must assure access to any qualified provider of Family Planning Services without requiring a referral from the PCP.				
The Contractor shall maintain confidentiality for Family Planning Services in accordance with applicable federal and state laws and judicial opinions for Members under eighteen (18) years of age pursuant to Title X, 42 CFR 59.11, and KRS 214.185. Situations under which confidentiality may not be guaranteed are described in KRS 620.030, KRS 209.010 et. seq., KRS 202A, and KRS 214.185.				

Quality Assessment and Performance Improvement: Access

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	5	1	0	0
Total Points	15	2	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.83**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable	Statement does not require a review decision

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Quality Assessment and Performance Improvement: Access
Suggested Evidence

Documents

Policies/procedures for:

- PCP responsibilities
- Provider hours of operation and availability, including after-hours availability
- Provider program capacity requirements
- Access and availability standards
- Emergency care, urgent care and post stabilization care
- Out-of-network emergency care
- Direct access services
- Referral for non-covered services
- Referral and assistance with scheduling for specialty health care services

Process for monitoring of provider compliance with hours of operation and availability, including after-hours availability
Process for monitoring of provider compliance with PCP responsibilities
Sample provider contracts – one per provider type
Provider Manual
Benefit Summary (covered/non-covered services)
Corrective action plan submitted to DMS for inadequate access, if applicable

Reports

Monitoring and follow-up of provider compliance with hours of operation and availability, including after-hours availability
Monitoring of provider compliance with PCP responsibilities
Provider Access and Availability Reports
Provider program capacity/program mapping reports including geo access, in required format for:

- Primary care
- Specialty care
- Emergency care
- Hospital care

- General dental services
- General vision, laboratory and radiology services
- Pharmacy services

Evidence of evaluation, analysis and follow-up related to provider program capacity reports
Reports of Out-of-Network Utilization
Evidence of evaluation, analysis and follow-up related to out-of-network utilization monitoring

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CoventryCares of Kentucky (CCKY)
Quality Assessment and Performance Improvement: Access – Utilization Management (2014)

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Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
20.6 Utilization Management				
The Contractor shall have a comprehensive UM program that reviews services for Medical Necessity and that monitors and evaluates on an ongoing basis the appropriateness of care and services.				
A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities between the Contractor and entities to which the Contractor delegates UM activities.				
The description shall include the scope of the program;				
the processes and information sources used to determine service coverage;				
clinical necessity, appropriateness and effectiveness;				
policies and procedures to evaluate care coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery;	Substantial - UM Program 2011-2012 addresses most of the requirements. P/P UM – 051, Discharge Planning and P/P UM-004, Continuity Coordination of Care address this requirement. **Recommendation for Coventry Cares** It is recommended that triage decisions be addressed in the UM Program.	Full	Addressed in CCKY UM Program Description 2013.	

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
processes to review, approve, and deny services as needed.				
The UM program shall be evaluated annually, including an evaluation of clinical and service outcomes.				
The UM program evaluation along with any changes to the UM program as a result of the evaluation findings, will be reviewed and approved annually by the Medical Director or the QI Committee.				
The Contractor shall adopt national recognized standards and criteria which shall be approved by the Department.				
The Contractor shall include appropriate physicians and other providers in Contractor's Network in the review and adoption of Medical Necessity criteria.				
The Contractor shall have in place mechanisms to check the consistency of application of review criteria.				
The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate.				
The Medical Director shall supervise the UM program and shall be accessible and available for consultation as needed. Decisions to deny				

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a physician who has appropriate clinical expertise in treating the Member's condition or disease.				
The reason for the denial shall be cited.				
Physician consultants from appropriate medical and surgical specialties shall be accessible and available for consultation as needed.				
The Medical Necessity review process shall be timely and shall include a provision for expedited reviews in urgent decisions.				
A. The Contractor shall submit its request to change any prior authorization requirement to the Department for review.				
B. For the processing of requests for initial and continuing authorization of services, the Contractor shall require that its subcontractors have in place written policies and procedures and have in effect a mechanism to ensure consistent application of review criteria for authorization decisions.				
C. In the event that a Member or Provider requests written confirmation of an approval, the Contractor shall provide written confirmation of its decision within two working days of providing notification of a decision if the decision was not in writing. The				

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
written confirmation shall be written in accordance with Member Rights and Responsibilities.				
D. The Contractor shall have written policies and procedures that show how the Contractor will monitor to ensure clinical appropriate overall continuity of care.				
E. The Contractor shall have written policies and procedures that explain how prior authorization data will be incorporated into the Contractor's overall Quality Improvement Plan.				
Each subcontract must provide that consistent with 42 CFR Sections 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to a Member.				
The program shall identify and describe the mechanisms to detect under-utilization as well as over-utilization of services.	Substantial - P/P UM – 017, Monitoring of Over/Under Utilization not provided for review. UM Program 2011-2012 addresses this requirement. **Recommendation for Coventry Cares** The plan should provide requested documentation.	Full	P/P UM-017, Monitoring of Over and Under Utilization addresses this requirement. Examples of reports used for monitoring purposes include: select HEDIS measures, adverse events and quality of care issues, UM reports, inpatient utilization, ER utilization, adverse determinations. Reports are reviewed and analyzed by the QM/UM and Service Advisory subcommittees. This requirement is also addressed in the	

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			2013 UM Program Description.	
The written program description shall address the procedures used to evaluate Medical Necessity, the criteria used, information sources, timeframes and the process used to review and approve the provision of medical services.				
The Contractor shall evaluate Member satisfaction (using the CAHPS survey) and provider satisfaction with the UM program as part of its satisfaction surveys.				
The UM program will be evaluated by DMS on an annual basis.				
20.7 Adverse Actions Related to Medical Necessity or Coverage Denials				
The Contractor shall give the Member written notice that meets the language and formatting requirements for Member materials, of any action (not just service authorization actions) within the timeframes for each type of action pursuant to 42 CFR 438.210(c). The notice must explain:				
(a) The action the Contractor has taken or intends to take;				
(b) The reasons for the action;				
(c) The Member's right to appeal;				
(d) The Member's right to request a State hearing;	Substantial - The MCO provided the following member letters as	Full	Addressed in P/P APP-002, Appeals Members and Member Handbook.	

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	evidence: • Mem_Medicaid Appeal – Upheld Denial • Mem_Medical Partial Approval letter. Member Handbook – Grievance and Appeals addresses this requirement. **Recommendation for Coventry Cares** P/P APP – 002, Appeals Members should be revised to include this requirement.			
(e) Procedures for exercising Member's rights to appeal or file a grievance;				
(f) Circumstances under which expedited resolution is available and how to request it; and				
(g) The Member's rights to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.	Substantial - Member Handbook – Grievance and Appeals addresses this requirement. **Recommendation for Coventry Cares** P/P UM-008, Notice of Action should be revised to include continuation of benefits.	Substantial	Addressed in Member Handbook. P/P UM-008 Notice of Action does not address this requirement. **Recommendation for CCKY** P/P UM-008, Notice of Action should be revised to include continuation of benefits.	P/P UM-008 has been updated to include continuation of benefits and is on the agenda for the next Policies and Procedures committee meeting for review and approval.
The Contractor must give notice at least: A. Ten (10) days before the date of Action				

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
when the Action is a termination, suspension, or reduction of a covered service authorized by the Department, its agent or Contractor, except the period of advanced notice is shortened to 5 days if Member Fraud or Abuse has been determined.				
B. The Contractor must give notice by the date of the Action for the following:				
1. In the death of a Member;				
2. A signed written Member statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information);				
3. The Member's admission to an institution where he is ineligible for further services;				
4. The Member's address is unknown and mail directed to him has no forwarding address;				
5. The Member has been accepted for Medicaid services by another local jurisdiction;				
6. The Member's physician prescribes the change in the level of medical care;				
7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989;				

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
8. The safety or health of individuals in the facility would be endangered, the Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or a Member has not resided in the nursing facility for thirty (30) days.				
C. The Contractor must give notice on the date of the Action when the Action is a denial of payment.				
D. The Contractor must give notice as expeditiously as the Member's health condition requires and within State-established timeframes that may not exceed two (2) business days following receipt of the request for service, with a possible extension of up to fourteen (14) additional days, if the Member, or the Provider, requests an extension, or the Contractor justifies a need for additional information and how the extension is in the Member's interest.				
If the Contractor extends the timeframe, the Contractor must give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision; and issue and carry out the determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.				

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
E. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than two (2) working days after receipt of the request for service.				
F. The Contractor shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. An untimely service authorization constitutes a denial and is thus and adverse action.				

Quality Assessment and Performance Improvement: Access – Utilization Management

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	3	1	0	0
Total Points	9	2	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.75**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Quality Assessment and Performance Improvement: Access – Utilization Management
Suggested Evidence

Documents

Policies/procedures for:

- Utilization management
- Review and adoption of medical necessity criteria
- Monitoring to ensure clinically appropriate overall continuity of care
- Incorporation of prior authorization data into QI plan

UM Program Description
Contracts with any subcontractors delegated for UM
Evidence of provider involvement in the review and adoption of medical necessity criteria
UM Committee description and minutes
Process for detecting under-utilization and over-utilization of services

Reports

UM Program Evaluation
Monitoring of consistent application of review criteria and any follow-up actions
CAHPS Report
Provider Satisfaction Survey Report

File Review

Sample of UM files selected by EQRO

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CoventryCares of Kentucky (CCKY)
Program Integrity (2014)

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Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
36. Program Integrity				
The Contractor shall have arrangements and policies and procedures that comply with all state and federal statutes and regulations including 42 CFR 438.608 and Section 6032 of the Federal Deficit Reduction Act of 2005, governing fraud, waste and abuse requirements.				
The Contractor shall develop in accordance with Appendix M, a Program Integrity plan of internal controls and policies and procedures for preventing, identifying and investigating enrollee and provider fraud, waste and abuse. This plan shall include, at a minimum:				
A. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;				
B. The designation of a compliance officer and a compliance committee that are accountable to senior management;				
C. Effective training and education for the compliance officer, the organization's employees, subcontractors, providers and members regarding fraud, waste and abuse;				
D. Effective lines of communication between the compliance officer and the organization's employees;				
E. Enforcement of standards through disciplinary guidelines;				

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
F. Provision for internal monitoring and auditing of the member and provider;				
G. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Contractor's contract;				
H. Provision for internal monitoring and auditing of Contractor and its subcontractors; if issues are found Contractor shall provide corrective action taken to the Department;				
I. Contractor shall be subject to on-site review; and comply with requests from the department to supply documentation and records;				
J. Contractor shall create an account receivables process to collect outstanding debt from members or providers; and provide monthly reports of activity and collections to the department;				
K. Contractor shall provide procedures for appeal process;				
L. Contractor shall comply with the expectations of 42 CFR 455.20 by employing a method of verifying with member whether the services billed by provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;				
M. Contractor shall create a process for card sharing cases;				
N. Contractor shall run algorithms on Claims				

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
data and develop a process and report quarterly to the Department all algorithms run, issues identified, actions taken to address those issues and the overpayments collected;				
O. Contractor shall follow cases from the time they are opened until they are closed; and				
P. Contractor shall attend any training given by the Commonwealth/Fiscal Agent or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.				
The plan shall be made available to the Department for review and approval.				
10.1 Administration/Staffing				
The Contractor shall provide the following functions that shall be staffed by a sufficient number of qualified persons to adequately provide for the member enrollment and services provided.				
B. A Compliance Director whose responsibilities shall be to ensure financial and programmatic accountability, transparency and integrity. The Compliance Director shall maintain current knowledge of Federal and State legislation, legislative initiatives, and regulations relating to Contractor and oversee the Contractor's compliance with the laws and Contract requirements of the Department. The Compliance Director shall also serve as the primary contact for and facilitate communications between Contractor				

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
leadership and the Department relating to Contract compliance issues. The Compliance Director shall also oversee Contractor implementation of and evaluate any actions required to correct a deficiency or address noncompliance with Contract requirements as identified by the Department.				
Q, A Program Integrity Coordinator who shall coordinate, manage and oversee the Contractor's Program Integrity unit to reduce fraud and abuse of Medicaid services.				
37.15 Ownership and Financial Disclosure				
The Contractor agrees to comply with the provisions of 42 CFR 455.104. The Contractor shall provide true and complete disclosures of the following information to Finance, the Department, CMS, and/or their agents or designees, in a form designated by the Department (1) at the time of each annual audit, (2) at the time of each Medicaid survey, (3) prior to entry into a new contract with the Department, (4) upon any change in operations which affects the most recent disclosure report, or (5) within thirty-five (35) days following the date of each written request for such information:	Minimal - See sub-requirements below. **MCO Response:** CoventryCares of Kentucky has requested annual disclosure of ownership information from its Subcontractors. ADOs that have been received to date are included. Additionally, COM-006 Delegated Vendor Oversight policy has been updated to address this annual reporting requirement.	Full	COM-006 Delegated Vendor Oversight policy was updated in 2013 to address this annual reporting requirement. Added was 'The activities of the DVOC are reported to the Executive Quality Improvement Committee (EQIC)'. CCKY provided the completed ADO for its subcontractors. DVOC is the Delegated Vendor Oversight Committee.	
A. The name and address of each person with an ownership or control interest in (i) the Contractor or (ii) any Subcontractor or supplier in which the Contractor has a direct or indirect ownership of five percent (5%) or more, specifying the relationship of any listed persons	Minimal - 2012 Annual Disclosure of Ownership provided addressing Coventry Cares. Disclosure information for subcontractors not provided, only contract provisions.	Full	CCKY ADO document listed Aetna Health Holdings, LLC (direct ownership) as the only controlling interest of 5% or more. A total of 6 entities were reviewed and findings are noted below:	

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
who are related as spouse, parent, child, or sibling;	Annual Disclosure Review Coventry Health and Life Insurance Company: 10 officers identified, one name noted on EPLS; Coventry Cares should check accuracy of this finding with officer's SSN. Coventry Health Care Inc.: 16 officers identified, none listed on excluded lists. **MCO Response:** CoventryCares of Kentucky has requested annual disclosure of ownership information from its Subcontractors. ADOs that have been received to date are included. Additionally, COM-006 Delegated Vendor Oversight policy has been updated to address this annual reporting requirement.		1. AM Specialty Health 2. Chamberin Edmonds 3. Coventry Health and Life 4. Coventry Health Care 5. NIA 6. Triad No officers were listed on the excluded list.	
B. The name of any other entity receiving reimbursement through the Medicare or Medicaid programs in which a person listed in response to subsection (a) has an ownership or control interest;	Minimal - 2012 Annual Disclosure of Ownership provided addressing Coventry Cares. Disclosure information for subcontractors not provided, only contract provisions. **MCO Response:** CoventryCares of Kentucky has requested annual disclosure of ownership information from its Subcontractors. ADOs that have been received to date are included. Additionally, COM-006 Delegated Vendor Oversight policy has been updated to address this annual reporting requirement.	Full	ADO information addressed through documentation for CCKY and its subcontractors.	

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
C. The same information requested in subsections (a) and (b) for any Subcontractors or suppliers with whom the Contractor has had business transactions totaling more than $250,000 during the immediately preceding twelve-month period;				
D. A description of any significant business transactions between the Contractor and any wholly-owned supplier, or between the Contractor and any Subcontractor, during the immediately preceding five-year period;				
E. The identity of any person who has an ownership or control interest in the Contractor, any Subcontractor or supplier, or is an agent or managing employee of the Contractor, any Subcontractor or supplier, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the services program under Title XX of the Act, since the inception of those programs;	Minimal - Addressed in 2012 Annual Disclosure of Ownership for Coventry Cares. Disclosure information for subcontractors not provided. **MCO Response:** CoventryCares of Kentucky has requested annual disclosure of ownership information from its Subcontractors. ADOs that have been received to date are included. Additionally, COM-006 Delegated Vendor Oversight policy has been updated to address this annual reporting requirement.	Full	ADO information addressed through documentation for CCKY and its subcontractors.	
F. The name of any officer, director, employee or agent of, or any person with an ownership or controlling interest in, the Contractor, any Subcontractor or supplier, who is also employed by the Commonwealth or any of its agencies; and	Minimal - Addressed in 2012 Annual Disclosure of Ownership for Coventry Cares. Disclosure information for subcontractors not provided. **MCO Response:** CoventryCares of Kentucky has requested annual	Non-Compliance	The ADO documentation provided did not address any employment activities with the Commonwealth. **Recommendation for CCKY** ADO documentation should include	All employees are screened and attest to any employment that may cause a conflict of interest. Every applicant is specifically asked if they have any employment history with the Commonwealth of Kentucky and to disclose what that employment

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	disclosure of ownership information from its Subcontractors. ADOs that have been received to date are included. Additionally, COM-006 Delegated Vendor Oversight policy has been updated to address this annual reporting requirement.		disclosure of employment with the Commonwealth or any of its agencies.	relationship was. Any questionable relationship is escalated from the recruiter to the plan Compliance Officer and Legal Counsel for review of conflicts. These must be signed off on before hiring can continue. All Board of Directors, Officers, and any person with an ownership or controlling interest is required to complete and submit conflict of interest to corporate compliance/legal. Anyone who had employment with the Commonwealth and their employment relationship cannot easily assessed is asked to obtain a release from the KY Ethics Review Board.
G. The Contractor shall be required to notify the Department immediately when any change in ownership is anticipated. The Contractor shall submit a detailed work plan to the Department and to the DOI during the transition period no later than the date of the sale that identifies areas of the contract that may be impacted by the change in ownership including management and staff.				
State Contract, Appendix M				
ORGANIZATION: The Contractor's Program Integrity Unit (PIU) shall be organized so that:				
A. Required Fraud, Waste and Abuse activities shall be conducted by staff that shall have sufficient authority to direct PIU activities; and				

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
shall include written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state regulations and standards;				
B. The unit shall be able to establish, control, evaluate and revise Fraud, Waste and Abuse detection, deterrent and prevention procedures to ensure their compliance with Federal and State requirements;				
C. Adequate staff shall be assigned to the PIU to enable them to conduct the functions specified in this Appendix on a continuous and on-going basis; and staffing shall consist of a compliance officer, auditing and clinical staff;				
D. The unit shall be able to prioritize work coming into the unit to ensure that cases with the greatest potential program impact are given the highest priority. Allegations or cases having the greatest program impact include cases involving:	Non-Compliance - Prioritization of cases not addressed in the documents provided. **MCO Response:** SIU investigators prioritize work based on potential impact to the program. Potential impact is measured by the affect on members' health and welfare or the potential dollar recovery. SIU data is aggregated across the entire company. If more resources are needed by a plan, again work is prioritized to assure appropriate focus on the highest impact. In addition, Coventry participates in national fraud prevention associations to keep abreast of trends and patterns.	Non-Compliance	As part of the onsite interview it was noted that CCKY does not have a written policy regarding prioritization. The Program Integrity (PI) Plan is across all of Coventry national. During the onsite interview, it was explained that staff of Special Investigative Unit (SIU) put membership /patient harms issues to the top of the list. Next are financial risks to the MCO or KY. Based on onsite interview, CCKY was to provide a document that detailed the logic, but it was not received. **Recommendation for CCKY** CCKY should prepare a document	The CoventryCares policy, SIU Medical Case Process" has been updated with the following language and will be presented to the Policies and Procedures Committee for review and approval. "If the investigation indicates an imminent threat to member safety or a significant projected portion of the plans assets, this must be brought to the attention of your Team Leader or Manager immediately for consideration of what actions should be taken to deal with the threat/issue. Manager will consult with the appropriate law department personnel within Plans legal and medical

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	IPRO Comments: No change in review determination. The MCO should document the prioritization process in a policy/procedure.		addressing the prioritization of the Fraud, Waste and Abuse (FWA) process for the KY contract.	department on next steps." *By the time a "member imminent danger" case is referred to SIU for investigation it has already been reported to DCBS/OIG/APS under our CM-033 Reporting Alleged Child Abuse or Neglect or CM-34 Reporting Alleged Adult Abuse or Neglect. CCKY does not wait to refer a case to SIU before notifying the proper authorities. The case would be reported and then it would be sent to SIU for further investigation. In cases, where additional evidence of other abuse is discovered during an investigation, the above process would occur.
(1) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing service area boundaries;	Non-Compliance - Prioritization of cases not addressed in the documents provided. **MCO Response:** SIU investigators prioritize work based on potential impact to the program. Potential impact is measured by the affect on members' health and welfare or the potential dollar recovery. SIU data is aggregated across the entire company. If more resources are needed by a plan, again work is prioritized to assure appropriate focus on the highest impact. In addition, Coventry participates in national fraud prevention associations to keep abreast	Non-Compliance	It was noted at the onsite interview that CCKY is a multi state organization that shares information among state lines of business. The MCO participates in USDOJ quarterly meetings and private State quarterly meetings regarding specific providers. CCKY performs data mining to provide cases to the State on a quarterly basis. Algorithms are given to State. **Recommendation for CCKY** CCKY should document the prioritization process for the KY contract in a policy and procedure.	The CoventryCares policy, SIU Medical Case Process" has been updated with the following language and will be presented to the Policies and Procedures Committee for review and approval. "If the investigation indicates an imminent threat to member safety or a significant projected portion of the plans assets, this must be brought to the attention of your Team Leader or Manager immediately for consideration of what actions should be taken to deal with the threat/issue. Manager will consult with the

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	of trends and patterns. **IPRO Comments:** No change in review determination. The MCO should document the prioritization process in a policy/procedure.			appropriate law department personnel within Plans legal and medical department on next steps." *By the time a "member imminent danger" case is referred to SIU for investigation it has already been reported to DCBS/OIG/APS under our CM-033 Reporting Alleged Child Abuse or Neglect or CM-34 Reporting Alleged Adult Abuse or Neglect. CCKY does not wait to refer a case to SIU before notifying the proper authorities. The case would be reported and then it would be sent to SIU for further investigation. In cases, where additional evidence of other abuse is discovered during an investigation, the above process would occur.
(2) High dollar amount of potential overpayment; or	Non-Compliance - Prioritization of cases not addressed in the documents provided. **MCO Response:** SIU investigators prioritize work based on potential impact to the program. Potential impact is measured by the affect on members' health and welfare or the potential dollar recovery. SIU data is aggregated across the entire company. If more resources are needed by a plan, again work is prioritized to assure appropriate focus on the highest impact. In addition,	Non-Compliance	As part of the onsite interview it was noted that CCKY does not have a written policy regarding prioritization. The Program Integrity (PI) Plan is across all of Coventry national. During the onsite interview, it was explained that staff of Special Investigative Unit (SIU) put membership /patient harms issues to the top of the list. Next are financial risks to the MCO or KY. Based on onsite interview, CCKY was to provide a document that detailed the logic, but it was not received.	The CoventryCares policy, SIU Medical Case Process" has been updated with the following language and will be presented to the Policies and Procedures Committee for review and approval. "If the investigation indicates an imminent threat to member safety or a significant projected portion of the plans assets, this must be brought to the attention of your Team Leader or Manager immediately for consideration of what actions should

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Coventry participates in national fraud prevention associations to keep abreast of trends and patterns. **IPRO Comments:** No change in review determination. The MCO should document the prioritization process in a policy/procedure.		**Recommendation for CCKY** CCKY should prepare a document addressing the prioritization of the FWA process for the KY contract.	be taken to deal with the threat/issue. Manager will consult with the appropriate law department personnel within Plans legal and medical department on next steps." *By the time a "member imminent danger" case is referred to SIU for investigation it has already been reported to DCBS/OIG/APS under our CM-033 Reporting Alleged Child Abuse or Neglect or CM-34 Reporting Alleged Adult Abuse or Neglect. CCKY does not wait to refer a case to SIU before notifying the proper authorities. The case would be reported and then it would be sent to SIU for further investigation. In cases, where additional evidence of other abuse is discovered during an investigation, the above process would occur.
(3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern.	Non-Compliance - Prioritization of cases not addressed in the documents provided. **MCO Response:** SIU investigators prioritize work based on potential impact to the program. Potential impact is measured by the affect on members' health and welfare or the potential dollar recovery. SIU data is aggregated across the entire company. If more resources are needed by a plan, again	Non-Compliance	As part of the onsite interview it was noted that CCKY does not have a written policy regarding prioritization. The Program Integrity (PI) Plan is across all of Coventry national. During the onsite interview, it was explained that staff of Special Investigative Unit (SIU) put membership /patient harms issues to the top of the list. Next are financial risks to the MCO or KY. Based on onsite interview, CCKY	The CoventryCares policy, SIU Medical Case Process" has been updated with the following language and will be presented to the Policies and Procedures Committee for review and approval. "If the investigation indicates an imminent threat to member safety or a significant projected portion of the plans assets, this must be brought to the attention of your Team Leader or

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	work is prioritized to assure appropriate focus on the highest impact. In addition, Coventry participates in national fraud prevention associations to keep abreast of trends and patterns. **IPRO Comments:** No change in review determination. The MCO should document the prioritization process in a policy/procedure.		was to provide a document that detailed the logic, but it was not received. **Recommendation for CCKY** CCKY should prepare a document addressing the prioritization of the FWA process for the KY contract.	Manager immediately for consideration of what actions should be taken to deal with the threat/issue. Manager will consult with the appropriate law department personnel within Plans legal and medical department on next steps." *By the time a "member imminent danger" case is referred to SIU for investigation it has already been reported to DCBS/OIG/APS under our CM-033 Reporting Alleged Child Abuse or Neglect or CM-34 Reporting Alleged Adult Abuse or Neglect. CCKY does not wait to refer a case to SIU before notifying the proper authorities. The case would be reported and then it would be sent to SIU for further investigation. In cases, where additional evidence of other abuse is discovered during an investigation, the above process would occur.
E. Contractor shall provide ongoing education to Contractor staff on Fraud, Waste and Abuse trends including CMS initiatives;				
F. Contractor shall attend any training given by the Commonwealth/Fiscal Agent or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.				
FUNCTION:				

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall establish a PIU to identify and refer to the Department any suspected Fraud or Abuse of Members and Providers. The Contractor's PIU shall be responsible for:				
A. Preventing Fraud, Waste and Abuse by identifying vulnerabilities in the Contractor's program including identification of member and provider Fraud, Waste and Abuse and taking appropriate action including but not limited to the following: (1) Recoupment of overpayments; (2) Changes to policy; (3) Dispute resolution meetings; and (4) Appeals.				
B. Proactively detecting incidents of Fraud, Waste and Abuse that exist within the Contractor's program through the use of algorithm, investigations and record reviews;				
C. Determining the factual basis of allegations through investigation concerning fraud or abuse made by Members, Providers and other sources;				
D. Initiating appropriate administrative actions to collect overpayments, deny or to suspend payments that should not be made;				
E. Referring potential Fraud, Waste and Abuse cases to the OIG (and copying DMS) for preliminary investigation and possible referral for civil and criminal prosecution and administrative sanctions;				
F. Initiating and maintaining network and outreach activities to ensure effective interaction and exchange of information with				

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
all internal components of the Contractor as well as outside groups;				
G. Making and receiving recommendations to enhance the Contractor's ability to prevent, detect and deter Fraud, Waste or Abuse;				
H. Providing prompt response to detected offenses and developing corrective action initiatives relating to the Contractor's contract;				
I. Providing for internal monitoring and auditing of Contractor and it subcontractors; and supply the department with quarterly reports on the activity and ad hocs as necessary;	Minimal - Internal monitoring and auditing are addressed in the PIP. Provision of quarterly reports to the Department related to subcontractors is noted. It is not evident that Coventry Cares reports internal monitoring and auditing activities for the Contractor itself. **MCO Response:** The plan has launched a Service Advisory Oversight Committee for internal monitoring and audits, as necessary. The organizational meeting was held on April 17, 2013. The next quarterly meeting is scheduled for July 31, 2013. The Service Advisory Committee members and responsibilities are enclosed. Service Advisory Committee Minutes are reported to the Executive Quality Improvement Committee. Minutes of the EQIC are reported to the Department as part of routine state reporting.	Full	Exhibit 1E Code of Business Conduct and Ethics addresses internal personnel. Monthly report 72 is required to be sent to the State. Delegated vendor oversight committee provides this report to the state and meets monthly.	
J. Being subject to on-site review and fully				

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
complying with requests from the department to supply documentation and records; and				
K. Creating an account receivables process to collect outstanding debt from members or providers and providing monthly reports of activity and collections to the department.				
The Contractor's PIU shall:				
A. Conduct continuous and on-going reviews of all MIS data including Member and Provider Grievances and Appeals for the purpose of identifying potentially fraudulent acts;				
B. Conduct regularly scheduled post-payment audits of provider billings, investigate payment errors, produce printouts and queries of data and report the results of their work to the Contractor, the Department, and OIG;				
C. Conduct onsite and desk audits of providers and report the results to the Department, including any overpayments identified;				
D. Maintain locally cases under investigation for possible Fraud, Waste or Abuse activities and provide these lists and entire case files to the Department and OIG upon demand;				
E. Designate a contact person to work with investigators and attorneys from the Department and OIG;				
F. Ensure the integrity of PIU referrals to the Department. Referrals if appropriate by the unit shall not be subject to the approval of the				

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Contractor's management or officials;				
G. Comply with the expectations of 42 CFR 455.20 by employing a method of verifying with member whether the services billed by provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;				
H. Run algorithms on claims data and develop a process and report quarterly to the department all algorithms run, issues identified, actions taken to address those issues and the overpayments collected;				
I. Have a method for collecting administratively on member overpayments that were declined prosecution, known as Medicaid Program Violations (MPV) letters, and recover payments from the member;				
J. Comply with the program integrity requirements set forth in 42 CFR 438.608 and provide policies and procedures to the Department for review;				
K. Report any provider denied enrollment by Contractor for any reason, including those contained in 42 CFR 455.106, to the Department within 5 days of the enrollment denial;	Minimal - Coventry noted CP-012 Provider Terminations and Member Moves as evidence, however this document was not provided. **MCO Response:** Please see emails to DMS which document the reporting and the reason for termination or denied enrollment.	Full	CP-012 Provider Terminations and Member Moves addresses that CCKY will submit to the Commonwealth of Kentucky notification of provider's termination. All terminations are reported to the Commonwealth monthly and within 5 days of an enrollment denial; an email is sent to State.	

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	IPRO Comments: Review determination changed to Minimal. Coventry (CVTY) Provider Terms report for 12/12 provided demonstrating reporting to DMS. Process should be documented in a policy/procedure.			
L. Have a method for recovering overpayments from providers;				
M. Comply with the program integrity requirements of the Patient Protection and Affordable Care Act as directed by the Department;				
N. Correct any weaknesses, deficiencies, or noncompliance items that are identified as a result of a review or audit conducted by DMS, CMS, or by any other State or Federal Agency that has oversight of the Medicaid program. Corrective action shall be completed the earlier of 30 calendar days or the timeframes established by Federal and state laws and regulations; and				
O. Work cooperatively and collaboratively with the Department to enhance the contractors PIU and to address any deficiencies identified.				
PATIENT ABUSE: Incidents or allegations concerning physical or mental abuse of Members shall be immediately reported to the Department for Community Based Services in accordance with state law and carbon copy the Department for Medicaid Services and OIG.	Non-Compliance - Addressed in PIP: states that cases involving member safety (abuse) are reported to the health plan medical director for review. Does not address requirement for notifying DCBS, DMS and OIG.	Non-Compliance	The Program Integrity Plan states that cases involving member safety (abuse) are reported to the health plan medical director for review. The Plan does not address requirement for notifying DCBS, DMS and OIG.	The CoventryCares policy, SIU Medical Case Process" has been updated with the following language and will be presented to the Policies and Procedures Committee for review and approval.

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	MCO Response: Please see the new policies which will be submitted through the Policies & Procedures Committee for review and approval.		**Recommendation for CCKY** PIP should address notification requirements.	"If the investigation indicates an imminent threat to member safety or a significant projected portion of the plans assets, this must be brought to the attention of your Team Leader or Manager immediately for consideration of what actions should be taken to deal with the threat/issue. Manager will consult with the appropriate law department personnel within Plans legal and medical department on next steps." *By the time a "member imminent danger" case is referred to SIU for investigation it has already been reported to DCBS/OIG/APS under our CM-033 Reporting Alleged Child Abuse or Neglect or CM-34 Reporting Alleged Adult Abuse or Neglect. CCKY does not wait to refer a case to SIU before notifying the proper authorities. The case would be reported and then it would be sent to SIU for further investigation. In cases, where additional evidence of other abuse is discovered during an investigation, the above process would occur.

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
COMPLAINT SYSTEM: The Contractor's PIU shall operate a process to receive, investigate and track the status of Fraud, Waste and Abuse complaints received from members, providers and all other sources which may be made against the Contractor, providers or members. The process shall contain the following:				
A. Upon receipt of a complaint or other indication of potential fraud or abuse, the Contractor's PIU shall conduct a preliminary inquiry to determine the validity of the complaint;				
B. The PIU should review background information and MIS data; however, the preliminary inquiry should not include interviews with the subject concerning the alleged instance of Fraud or Abuse;				
C. Should the preliminary inquiry result in a reasonable belief that the complaint does not constitute Fraud or Abuse, the PIU should not refer the case to OIG; however, the PIU should take whatever actions may be necessary, up to and including, administrative recovery of identified overpayments;				
D. Should the preliminary inquiry result in a reasonable belief that Fraud or Abuse has occurred, the PIU should refer the case and all supporting documentation to the Department, with a copy to OIG;				
E. OIG will review the referral and attached				

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
documentation and make a determination as to whether OIG will investigate the case or return it to the PIU for them to conduct a preliminary investigation;				
F. OIG will notify the PIU in a timely manner as to whether the OIG will investigate or whether the PIU should conduct a preliminary investigation;				
G. If in the process of conducting a preliminary investigation, the PIU suspects a violation of either criminal Medicaid fraud statutes or the Federal False Claims Act, the PIU shall immediately notify the Department with a copy to the OIG of their findings and proceed only in accordance with instructions received from the OIG;				
H. If OIG determines that it will keep a case referred by the PIU, the OIG will conduct an investigation, gather evidence, write a report and forward information to the Department and the PIU for appropriate actions;				
I. If OIG opens an investigation based on a complaint received from a source other than the Contractor, OIG will, upon completion of the investigation, provide a copy of the investigative report to DMS and the PIU for appropriate actions;				
J. If OIG investigation results in a referral to the Attorney General's Medicaid Fraud Control Unit and/or the U.S. Attorney, the OIG will notify DMS and the PIU of the referral. DMS				

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and the PIU should only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral;				
K. Upon approval of the Department, Contractor shall suspend provider payments in accordance with Section 6402 (h)(2) of the Affordable Care Act pending investigation of credible allegation of fraud; these efforts shall be coordinated through the Department;				
L. Upon completion of the PIU's preliminary investigation, the PIU should provide the Department and OIG a copy of their investigative report, which should contain the following elements:	Substantial - Addressed in PIP. A sample of 10 program integrity files were reviewed - 5 member files, 4 provider files and one ancillary provider file. Sub-requirement results are presented below. One file appeared untimely: file indicates that the case was closed on 7/13/12 with referral to OIG; referral to OIG sent 11/15/12. **Recommendation for Coventry Cares** The MCO should ensure that case investigations proceed to closure in a timely manner.	Full	Addressed in the Program Integrity policy. Program Integrity File Review 10 files were reviewed: 5 provider files and 5 member files. 10 of 10 files were compliant.	
(1) Name and address of subject,				
(2) Medicaid identification number,				
(3) Source of complaint,	Substantial - 9 of 10 files were compliant. One file states that a referral was received, however the source of the	Full	Program Integrity File Review 10 files were reviewed: 5 provider files and 5 member files. 10 of 10 files were	

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	referral is not specified. **Recommendation for Coventry Cares** The source of referral should be clearly documented in program integrity files.		compliant.	
(4) The complaint/allegation,				
(5) Date assigned to the investigator,				
(6) Name of investigator,	Substantial - 9 of 10 files were compliant. One file did not include the name of the investigator. **Recommendation for Coventry Cares** The name of the investigator should be clearly documented in program integrity files.	Full	Program Integrity File Review 10 files were reviewed: 5 provider files and 5 member files. 10 of 10 files were compliant.	
(7) Date of completion,				
(8) Methodology used during investigation,				
(9) Facts discovered by the investigation as well as the full case report and supporting documentation,	Non-Compliance - Files presented included a timeline of activities. A summary of attachments (listing all items pertaining to the investigative report) was not included in the files. **MCO Response:** Most cases reviewed were referrals from the Commonwealth. The member and/or provider are determined not to be associated with CoventryCares of Kentucky. For a full	Full	Program Integrity File Review 10 files were reviewed: 5 provider files and 5 member files. 10 of 10 files were compliant.	

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	investigation, please see the attached file which contains facts and supporting documentation.			
(10) All exhibits or supporting documentation,	Substantial - Supporting documentation was not evident in all the files provided. For example, the letter to the OIG was not included (one case); letter to the provider for recovery not included (one case). **Recommendation for Coventry Cares** Coventry Cares should ensure that case files include all supporting documentation.	Full	Program Integrity File Review 10 files were reviewed: 5 provider files and 5 member files. 10 of 10 files were compliant.	
(11) Recommendations as considered necessary, for administrative action or policy revision,				
(12) Overpayment identified, if any, and recommendation concerning collection.	Substantial - In one file, the MCO approved recovery of $6,556.85 on 11/18/12. Recovery submitted and education letter sent on 12/10/12 however these documents are not included in the file. File indicates that the case is closed however status/outcome of recovery is not documented. **Recommendation for Coventry Cares** Coventry Cares should ensure that case files include a listing of all pertinent	Not Applicable	No cases presented for overpayment.	

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	documents and interviews conducted during the investigation.			
M. The Contractor's PIU provide OIG and DMS a quarterly member and provider status report of all cases including actions taken to implement recommendations and collection of overpayments;				
N. The Contractor's PIU shall maintain access to a follow-up system which can report the status of a particular complaint or grievance process or the status of a specific recoupment; and				
O. The Contractor's PIU shall assure a Grievance and appeal process for Members and Providers in accordance with 907 KAR 1:671 and 907 KAR 1:563.				
REPORTING: The Contractor's PIU shall provide a quarterly in narrative report format all activities and processes for each investigative case (from opening to closure) to the Department within 30 calendar days of investigation closure. If any internal component of the Contractor discovers or is made aware of an incident of possible Member or Provider Fraud, Waste or Abuse, the incident shall be immediately reported to the PIU Coordinator. The Contractor's PIU shall report all cases of suspected Fraud, Waste, Abuse or inappropriate practices by Subcontractors, Members or employees to the Department and OIG.				

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor is required to report the following data elements to the Department and the OIG on a quarterly basis, in an excel format:				
(1) PIU Case number;				
(2) OIG Case number;				
(3) Provider/Member name;				
(4) Provider/Member number;				
(5) Date complaint received by Contractor;				
(6) Source of complaint, unless the complainant prefers to remain anonymous;				
(7) Date opened;				
(8) Summary of complaint;				
(9) Is complaint substantiated or not substantiated (Y or N answer only under this column);				
(10) PIU action taken (only provide the most current update);				
(11) Amount of overpayment (if any);				
(12) Administrative actions taken to resolve findings of completed cases including the following information:				
(a)The overpayment required to be repaid and overpayment collected to date;				
(b) Describe sanctions/withholds applied to				

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Providers/Members, if any;				
(c) Provider/Members appeal regarding overpayment or requested sanctions. If so, list the date an appeal was requested, date the hearing was held, the date of the final decision, and to the extent they have occurred;				
(d) Revision of the Contractor's policies to reduce potential risk from similar situations with a description of the policy recommendation, implemented of aforementioned revision and date of implementation; and				
(e) Make MIS system edit and audit recommendations as applicable.				
AVAILABILITY AND ACCESS TO DATA: The Contractor shall:				
A. Gather, produce, keep and maintain records including, but not limited to, ownership disclosure for all providers and subcontractors, submissions, applications, evaluations, qualifications, member information, enrollment lists, grievances, Encounter data, desk reviews, investigations, investigative supporting documentation, finding letters and subcontracts for a period of 5 years after contract end date;	Non-Compliance - Coventry noted that this is addressed in the plan's Record Retention Policy, however this policy was not provided for review. **MCO Response:** CoventryCares of Kentucky has requested annual disclosure of ownership information from its Subcontractors. Please see ADOs that have been received to date which are enclosed. Additionally, COM-006 Delegated Vendor Oversight policy has been updated to reflect annual reporting requirement.	Non-Compliance	P/Ps provided do not address requirement. Interviewer requested the retention policy at the onsite, but it was not provided. **Recommendation for CCKY** CCKY should address record retention requirements in a policy/procedure.	As the plan migrates to the Aetna platform the Records Retention and Destruction policy approved 5/22/14 will be adopted for CoventryCares of Kentucky. Today, Privacy-016, Storage and Disposal of Hardcopy PII/PHI includes language on records retention as well as UM-31, Clinical Record and Confidentiality and IS-004 Data Availability and Storage.
B. Regularly report enrollment, Provider and				

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Encounter data in a format that is useable by the Department and the OIG;				
C. Backup, store or be able to recreate reported data upon demand for the Department and the OIG;				
D. Permit reviews, investigations or audits of all books, records or other data, at the discretion of the Department or OIG, or other authorized federal or state agency; and, shall provide access to Contractor records and other data on the same basis and at least to the same extent that the Department would have access to those same records;				
E. Produce records in electronic format for review and manipulation by the Department and the OIG;				
F. Allow designated Department staff read access to ALL data in the Contractor's MIS systems; and				
G. Provide all contracted rates for providers upon request.				
The Contractor's PIU shall have access to any and all records and other data of the Contractor for purposes of carrying out the functions and responsibilities specified in this Contract.				
The Contractor shall cooperate with the OIG, the United States Attorney's Office and other law enforcement agencies in the investigation or fraud or abuse cases.				

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
In the event no action toward collection of overpayments is taken by the Contractor after one hundred and eighty (180) days the Commonwealth may begin collection activity and shall retain any overpayments collected. If the Contractor takes appropriate action to collect overpayments, the Commonwealth will not intervene.	Non-Compliance - Not addressed in the documents provided. **MCO Response:** Collection amounts and amounts collected are provided on state report # 72 monthly. This is a DMS action. Report #72 is enclosed. **IPRO Comments:** No change in review determination. Collection activity reported in Report #72 (dated 2013).	Non-Compliance	Not addressed in documents provided. **Recommendation for CCKY** CCKY should include this requirement in policy/procedure.	This continues to be reported in Report #72. Will present to Policies and Procedures meeting for review and approval of CSO-001, Claims Payment Timeliness.
The Contractor shall provide identity and cover documents and information for law enforcement investigators under cover.	Non-Compliance - Per Coventry this was discussed with DMS, and the plan is awaiting response on how they can put into effect and not create issues with the Enrollment file and payment pmpm. **MCO Response:** This is not a contract requirement. Further, CoventryCares of Kentucky cooperated with the MFCU and Cabinet to provide the credentials in spring 2012. The Cabinet took the matter under advisement. No further action or request has been made since that time.	Non-Compliance	CCKY provided a similar response to last year. Per CCKY, this was discussed with DMS, and the plan is awaiting response on how they can put into effect and not create issues with the Enrollment file and payment pmpm. No documentation was provided addressing this requirement. **Recommendation for CCKY** CCKY should include this requirement in policy/procedure.	This is not a contract requirement. The plan is awaiting response on how they can put into effect and not create issues with the Enrollment file and payment pmpm.

Program Integrity

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	11	0	0	9
Total Points	33	0	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	11	0	0	9
Total Points	33	0	0	0

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Program Integrity
Suggested Evidence

Documents

Policies/Procedures for:

- post payment audits
- internal monitoring and auditing
- preventive actions
- annual ownership and financial disclosure

Program Integrity Plan including related policies and procedures
Program Integrity training program and evidence of training for Compliance Officer, staff, providers, subcontractors and members
Program Integrity Unit description including Compliance Officer position description
Program Integrity Committee description and minutes
Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors and employees
Provider contract provisions for FWA
Vendor contract provisions for FWA

Reports

Evidence of PIU preventive actions and ongoing monitoring of MIS data
Monthly state reporting
Quarterly Program Integrity Reports

File Review

Program Integrity files for a random sample of cases chosen by EQRO
ADO files selected by EQRO

CoventryCares of Kentucky (CCKY)
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (2014)

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Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
8.4 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)				
The Contractor shall provide all Members under the age of twenty-one (21) years EPSDT services in compliance with the terms of this Contract and policy statements issued during the term of this Contract by the Department or CMS. The Contractor shall file EPSDT reports in the format and within the timeframes required by the terms of this Contract as indicated in Appendix J. The Contractor shall comply with 907 KAR 11:034 that delineates the requirements of all EPSDT providers participating in the Medicaid program.				
Health care professionals who meet the standards established in the above-referenced regulation shall provide EPSDT services. Additionally, the Contractor shall:				
A. Provide, through direct employment with the Contractor or by Subcontract, accessible and fully trained EPSDT Providers who meet the requirements set forth under 907 KAR 1:034*, and who are supported by adequately equipped offices to perform EPSDT services.	Minimal - P/P UM-047 and Provider Manual address this requirement. Q3 2012 MCO #24 report references an EPSDT Provider Reference Manual that was pending committee approval. It is not evident whether this manual has been approved or made available to providers. Evidence of provider training was not provided. The adequacy of the provider network to provide accessible	Full	P/P UM-028 and the EPSDT Provider Reference Manual address this requirement. Fax Blast to providers refers providers to the CCKY web site to find the manual. The fax blast included CCKY contact information for EPSDT. Based on onsite interview, EPSDT manual was sent out in 2013. Fax Blast sent in July 2013. Provider reps meet with offices to discuss EPSDT requirements. EPSDT coordinator may also hand deliver the EPSDT manual to providers.	

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	and fully trained EPSDT providers was not addressed in the documents provided. **MCO Response:** 1) The EPSDT Provider Manual was approved by the plan's Communications Review Team (CRT) on April 1, 2013. The EPSDT Provider Manual has been posted to the plan's website. The availability of the manual will be announced to providers through a Fax Blast, email and mail distribution to 3,000 Pediatric Providers and 800 health department offices throughout Kentucky. 2) The distribution of the EPSDT Provider Manual along with quarterly EPSDT updates in the Provider Newsletter will serve as the primary educational approach for Providers. 3) To provide access to the EPSDT Team members, the plan has shared the key contact names and numbers of the EPSDT Team Members for any questions or concerns.			

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	4) The plan's Provider Relations and Quality Outreach staff will serve as additional subject matter sources for the Providers. 5) Provider Relations Team EPSDT dedicated training session were held on 6/21/13. CoventryCares of Kentucky does not require special classification of EPSDT providers. Providers who are eligible under their license to provide services are permitted to provide EPSDT services to CoventryCares of Kentucky members.			
B. Effectively communicate information (e.g. written notices, verbal explanations, face to face counseling or home visits when appropriate or necessary) with members and their families who are eligible for EPSDT services [i.e. Medicaid eligible persons who are under the age of twenty-one (21)] regarding the value of preventive health care, benefits provided as part of EPSDT services, how to access these services, and the Member's right to access these services.				
Members and their families shall be informed about EPSDT and the right to Appeal any decision relating to Medicaid services, including EPSDT services, upon initial enrollment and annually thereafter where Members	Substantial - Member Handbook includes the member's right to appeal decisions related to Medicaid	Full	Member Handbook addresses this requirement. Appeal File Review	

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
have not accessed services during the year.	services, but does not specify EPSDT services. P/P QI -017 addresses this requirement. UM File Review Five UM decisions related to EPSDT (child members) were reviewed. All 5 files were completed timely and were compliant with UM contract requirements. Appeal File Review Five member appeals related to EPSDT (child members) were reviewed. No documentation was provided in the file for one case. Another file lacked an acknowledgment letter. The remaining 3 files were completed timely and were compliant. **Recommendation for Coventry Cares** The Member Handbook should include appeal rights for EPSDT services. Appeal files should include complete documentation including		Five member appeals related to EPSDT (child members) were reviewed. All files were completed timely and were compliant.	

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	acknowledgement letters.			
C. Provide EPSDT services to all eligible Members in accordance with EPSDT guidelines issued by the Commonwealth and federal government and in conformance with the Department's approved periodicity schedule, a sample of which is included in Appendix J.				
D. Provide all needed initial, periodic and inter-periodic health assessments in accordance with 907 KAR 1:034*. The Primary Care Provider assigned to each eligible member shall be responsible for providing or arranging for complete assessments at the intervals specified by the Department's approved periodicity schedule and at other times when Medically Necessary.				
E. Provide all needed diagnosis and treatment for eligible Members in accordance with 907 KAR 1:034*. The Primary Care Provider and other Providers in the Contractor's Network shall provide diagnosis and treatment, and/or Out-of-Network Providers may provide treatment if the service is not available with the Contractor's Network.				
F. Provide EPSDT Special Services for eligible members, including identifying providers who can deliver the Medically Necessary services described in federal Medicaid law and developing procedures for authorization and payment for these services. Current requirements for EPSDT Special Services are included in Appendix J.				
G. Establish and maintain a tracking system to monitor acceptance and refusal of EPSDT services, whether	Minimal - P/P UM-047 addresses tracking of	Substantial	This is addressed in the NavCare system. The EPSDT Team has chosen to	CoventryCares of Kentucky will ensure that all reports are presented during

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
eligible Members are receiving the recommended health assessments and all necessary diagnosis and treatment, including EPSDT Special Services when needed.	acceptance and refusal of EPSDT services. Evidence of monitoring of receipt/non-receipt of services provided. Evidence of tracking system for monitoring acceptance and refusal of EPSDT services by members was not provided. **MCO Response:** CoventryCares of Kentucky is implementing the following actions to address this finding: 1) Develop a tracking system to report and monitor acceptance and refusal of: a) EPSDT screening and b) EPSDT Special Services 2) Utilize existing monthly reports for tracking of: a) Lack of compliance based on frequency of missed visits b) Listing of members with non-assigned Provider and lack of compliance and c) Any member or family who refuses EPSDT Services		utilize this system to track all inbound and outbound based telephonic conversations with families. Policy CM-025 EPSDT Referrals presents the process for ensuring timely member compliance. Members are identified through the Cognos PCP Member Detail Report for well child visits. The coordinator follows up with members who have not been compliant with referral appointments for EPSDT services. A consolidated record is maintained in NavCare for each member. A NavCare screen shot along with the process was provided. A sample Cognos report was to be presented during the onsite visit but was not provided. **Recommendation for CCKY** A sample Cognos report should be provided for review.	future onsites, as requested. A CoventryCares of Kentucky compliance trend report from Cognos is being submitted for the EQRO's files.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	3) Implement scheduled member outreach process based on identification of EPSDT visit non-compliance at high level threshold. This is will be accomplished through a system enhancement to NavCare System to add EPSDT data fields for tracking of EPSDT coordinator outreach and follow-up. The request has been submitted and development meetings are scheduled.			
H. Establish and maintain an effective and on-going Member Services case management function for eligible members and their families to provide education and counseling with regard to Member compliance with prescribed treatment programs and compliance with EPSDT appointments. This function shall assist eligible Members or their families in obtaining sufficient information so they can make medically informed decisions about their health care, provide support services including transportation and scheduling assistance to EPSDT services, and follow up with eligible Members and their families when recommended assessments and treatment are not received.				
I. Maintain a consolidated record for each eligible member, including reports of informing about EPSDT,				

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
information received from other providers and dates of contact regarding appointments and rescheduling when necessary for EPSDT screening, recommended diagnostic or treatment services and follow-up with referral compliance and reports from referral physicians or providers.				
J. Establish and maintain a protocol for coordination of physical health services and Behavioral Health Services for eligible members with behavioral health or developmentally disabling conditions.				
Coordination procedures shall be established for other services needed by eligible members that are outside the usual scope of Contractor services. Examples include early intervention services for infants and toddlers with disabilities, services for students with disabilities included in the child's individual education plan at school, WIC, Head Start, Department for Community Based Services, etc.				
K. Participate in any state or federally required chart audit or quality assurance study.				
L. Maintain an effective education/ information program for health professionals on EPSDT compliance (including changes in state or federal requirements or guidelines). At a minimum, training shall be provided concerning the components of an EPSDT assessment, EPSDT Special	Minimal - P/P UM-047 and the Provider Manual address this requirement. Upon employment with the	Full	This was addressed through the following documents: KYPR00022 Provider Manual; EPSDT Provider Manual; 07 16 13 Provider Fax Blast – EPSDT Promotion	

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Services, and emerging health status issues among Members which should be addressed as part of EPSDT services to all appropriate staff and Providers, including medical residents and specialists delivering EPSDT services. In addition, training shall be provided concerning physical assessment procedures for nurse practitioners, registered nurses and physician assistants who provide EPSDT screening services.	MCO and annually, customer service and case management staff attend EPSDT training. A formal educational seminar was provided to case management staff. Per the Q3 2012 MCO Report #24, the plan developed an EPSDT Provider Reference Manual that is awaiting committee approval. Evidence of provider training was not provided. **MCO Response:** 1) The EPSDT Provider Manual was approved by the plan's Communications Review Team (CRT) on April 1, 2013. The EPSDT Provider Manual has been posted to the plan's website. The availability of the manual will be announced to providers through a Fax Blast, email and mail distribution to 3,000 Pediatric Providers and 800 health department offices throughout Kentucky.		and Education; CCKY Provider Newsletter Volume 1 Issue 1; EPSDT Educational Fax Blast Attendance Target July 2014. All training was done through electronic media.	

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	2) The distribution of the EPSDT Provider Manual along with quarterly EPSDT updates in the Provider Newsletter will serve as the primary educational approach for Providers. 3) To provide access to the EPSDT Team members, the plan has shared the key contact names and numbers of the EPSDT Team Members for any questions or concerns. 4) The plan's Provider Relations and Quality Outreach staff will serve as additional subject matter sources for the Providers. 5) Provider Relations Team EPSDT dedicated training session were held on 6/21/13. CoventryCares of Kentucky does not require special classification of EPSDT providers. Providers who are eligible under their license to			

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	provide services are permitted to provide EPSDT services to CoventryCares of Kentucky members.			
M. Submit Encounter Record for each EPSDT service provided according to requirements provided by the Department, including use of specified EPSDT procedure codes and referral codes. Submit quarterly and annual reports on EPSDT services including the current Form CMS-416.				
N. Provide an EPSDT Coordinator staff function with adequate staff or subcontract personnel to serve the Contractor's enrollment or projected enrollment.	Minimal - The MCO provided an Overview of EPSDT Coordinator Functions as evidence for this requirement. This document is not dated; not a formal position description. The EPSDT liaison position is vacant on the organizational chart provided. The EPSDT nurse position is staffed. **MCO Response:** The Medicaid Managed Care Contract states in Section 10.1, "The Contractor shall provide the following functions that shall be staffed by a sufficient number of qualified persons to adequately provide for the	Full	The ORG chart showed 1 EPSDT coordinator position. CCKY stated at the onsite interview that they use a proprietary formula for staffing ratios. ESPDT Coordinator as communicated to the Commonwealth is Debbie Moorhead, RN, Manager Health Services.	

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	member enrollment and services provided. Responsibility for these functions or staff positions may be provided by, combined with or split among Contractor's departments, people or Subcontractors and carry such titles as Contractor designates and provides to the Department." The role of EPSDT Coordinator is filled by multiple staff. The appointed ESPDT Coordinator as communicated to the Commonwealth is Debbie Moorhead, RN, Manager Health Services. Ms. Moorhead has deep experience in working with pediatric and neonatal providers and members. She leads our EPSDT initiative and uses the talents and skills of other clinical and clerical staff to track and monitor the EPSDT population. Please see the enclosed Organizational Chart.			

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
22.1 Required Functions				
L. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of 21 years.	Non-Compliance - The MCO provided an Overview of EPSDT Coordinator Functions as evidence for this requirement. This document is not dated; is not a formal position description and does not address the required function as stated in the contract requirement. **MCO Response:** The Medicaid Managed Care Contract states in Section 10.1, "The Contractor shall provide the following functions that shall be staffed by a sufficient number of qualified persons to adequately provide for the member enrollment and services provided. Responsibility for these functions or staff positions may be provided by, combined with or split among Contractor's departments, people or Subcontractors and carry such titles as Contractor designates and provides to the Department."	Full	The ORG chart showed 1 EPSDT coordinator position. CCKY stated at the onsite interview that they use a proprietary formula for staffing ratios. ESPDT Coordinator as communicated to the Commonwealth is Debbie Moorhead, RN, Manager Health Services.	

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	The role of EPST Coordinator is filled by multiple staff. The appointed ESPDT Coordinator as communicated to the Commonwealth is Debbie Moorhead, RN, Manager Health Services. Ms. Moorhead has deep experience in working with pediatric and neonatal providers and members. She leads our EPSDT initiative and uses the talents and skills of other clinical and clerical staff to track and monitor the EPSDT population. Please see the enclosed Organizational Chart.			
37.9 EPSDT Reports				
The Contractor shall submit Encounter Records to the Department's Fiscal Agent for each Member who receives EPSDT Services. This Encounter Record shall be completed according to the requirements provided by the Department, including use of specified EPSDT procedure codes and referral codes. Annually the Contractor shall submit a report on EPSDT activities, utilization and services and the current Form CMS-416 to the Department.				

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	5	1	0	0
Total Points	15	2	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.83**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Suggested Evidence

Documents

Policies/procedures for:

- EPSDT services
- Identification of members requiring EPSDT special services
- Education/information program for health professionals
- EPSDT provider requirements
- Coordination of physical health services and behavioral health services
- Coordination of other services, e.g., early intervention services

EPSDT member/provider ratio and case management ratio for EPSDT children with special needs
Evidence of communication of required EPSDT information with eligible members and families
EPSDT Coordinator position description
Description of tracking system to monitor acceptance and refusal of EPSDT services
Process for monitoring compliance with EPSDT services requirements including periodicity schedule
Evidence of case management function providing education and counseling for patient compliance
Process for ensuring follow-up evaluation, referral and treatment in response to EPSDT screening results
Linkage agreements between MCO providers and behavioral health providers to assure provision of EPSDT services
Copies of practitioner training materials and other educational/informational materials and attendance records
Process for calculating EPSDT participation and screening rates including quality control measures
Evidence of submission of EPSDT Encounter Records, including special EPSDT procedure codes and referral codes

File Review

Sample of UM and member and provider appeals related to EPSDT services selected by the EQRO

Reports

EPSDT reports (quarterly and annual 416 reports)
Annual EPSDT report of EPSDT activities, utilization and services

CoventryCares of Kentucky (CCKY)
Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (2014)

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Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
5.3 Delegations of Authority				
The Contractor shall oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor. In addition to the provision set forth in Subcontracts, Contractor agrees to the following provisions.	Coventry Cares subcontracts with 8 entities including: American Specialty Health (ASH) – chiropractic services Medco – pharmacy services National Imaging – radiology services Triad – musculoskeletal pain management services Avesis – dental services McKesson – advice line MH Net – behavioral health services VSP – vision services Coventry Cares also contracts with National Research Corporation (NRC) for conduct of Health Risk Assessments for its Kentucky members, and with Chamberlain Edmonds to identify members who may qualify for SSI.			
A. There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the Subcontractor and provides for revocation of the delegation or imposition of other sanctions if the Subcontractor's performance is inadequate.				

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. Before any delegation, the Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.	Substantial - Pre-delegation audits were provided for all subcontractors with the exception of ASH: Coventry Cares provided a pre-delegation audit dated 3/18/13. The audit indicates that the MCO has had a contract with ASH since November 2011. A pre-delegation audit prior to the date of delegation was not provided.	Full	CCKY subcontracts with seven (7) entities that provide delegated services including: American Specialty Health (ASH) – provides chiropractic services Avesis – provides dental services (began providing vision services 11/2013) Express Scripts, Inc. – (formerly MedCo) provides pharmacy services McKesson – provides an advice line MHNet – provides behavioral health services National Imaging – provides radiology services Triad – provides pain management services VSP – provides vision services (contract terminated 11/2013 during period of review) CCKY also contracts with National Research Corporation (NRC) which	

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			is an entity that conducts Health Risk Assessments and Chamberlin Edmonds which CCKY uses to identify members who may qualify for SSI. These two entities have no delegated services. This requirement is addressed in the Oversight of Delegated Subcontractors Policy. Pre-delegation audits were provided for all subcontractors.	
C. The Contractor shall monitor the Subcontractor's performance on an ongoing basis and subject the Subcontractor to a formal review at least once a year.	Minimal - Coventry Cares maintains a Subcontractor Oversight Committee. During the transition period, the MCO met weekly with subcontractors, eventually reducing to biweekly and currently monthly meetings. Documentation of oversight, ongoing and formal review, was provided for Medco (annual audit December 2012) and Avesis (annual audit October 2012). Evidence of ongoing monitoring and/or an annual audit was lacking for the following: ASH: Coventry Cares provided copies of meeting agendas and minutes for 2012/2013. Performance standard reports were not provided. MCO Report 15 indicates that penalties were assessed for failure to meet timely claims processing	Full	This requirement is addressed in the Oversight of Delegated Subcontractors Policy. Performance is monitored on an ongoing basis (at least quarterly) by means of a Subcontractor Oversight Committee. Meeting minutes from both the Committee and from the Committee's meetings with the subcontractor are provided as evidence of ongoing monitoring. Documentation of ongoing oversight and formal review was provided for the following subcontractors: American Specialty Health (ASH):	

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	standards and for not providing electronic encounter records. Follow-up regarding this issue was not evident in the documents provided. The MCO noted that the annual audit for ASH is currently in process. National Imaging: The annual audit for 2012 (reported January 2013) was provided. Evidence of ongoing oversight including monitoring of subcontractor reporting was not provided. Triad: Evidence of ongoing oversight including monitoring of subcontractor reporting was not provided. Annual audit not due yet. McKesson: Evidence of ongoing oversight including monitoring of subcontractor reporting not provided. Annual audit conducted (November 2012). MHNet: Evidence of ongoing oversight including monitoring of subcontractor reporting not provided. Annual audit conducted (October 2012). VSP: Evidence of ongoing oversight subcontractor reporting provided. Evidence of annual audit not provided **MCO Response:** CoventryCares of Kentucky		CCKY provided copies of meeting agendas and minutes for 2013. An annual audit was finalized 12/2013 with a CAP for ASH that will be monitored via quarterly meetings and the annual audit. A Delegation Evaluation Summary Report dated 12/2013 was provided that indicated follow-up on previous corrective action given to ASH. Avesis: CCKY provided evidence of ongoing monitoring (meeting minutes) as well as an Annual Audit Summary dated 12/2013. Express Scripts, Inc.: CCKY provided evidence of ongoing monitoring (meeting minutes) as well as an Annual Audit Summary dated 1/4/2014. MHNet: CCKY provided evidence of ongoing monitoring (meeting minutes) as well as an Annual Audit Summary dated 11/2013. National Imaging Associates (NIA): CCKY provided evidence of ongoing monitoring (meeting minutes) as well as an Annual Audit Summary dated 11/2013.	

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	has completed the delegation audits of ASH and Avesis. Reports to the Executive Quality Improvement Committee on the audits are included. CoventryCares of Kentucky has recently reorganized its structure related to delegated vendor/subcontractor oversight. A new director for Network Development has been hired and will take the lead in Subcontractor Oversight. To prepare for this transition, the Compliance Department and Quality Improvement Department have prepared summaries of individual subcontractor contract deliverables and NCQA requirements. Monthly meetings are scheduled with each subcontractor. Further, bi-monthly meetings of the Subcontractor Oversight Committee are scheduled in which the plan's contract liaisons will report on each subcontractor's performance. The Committee will review the performance and make recommendations for improvement and where appropriate, corrective action.		Triad: CCKY provided evidence of ongoing monitoring (meeting minutes) as well as an Annual Audit Summary dated 5/2013. VSP: CCKY provided evidence of ongoing monitoring (meeting minutes) and terminated their contract with VSP on 11/1/2013. Evidence was lacking for the following subcontractors: McKesson: An Annual Audit Summary dated 11/2013 was provided. During the onsite review, CCKY noted that McKesson is monitored by Corporate and provided evidence of correspondence and meeting minutes with corporate regarding McKesson CAP.	
D. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor shall take corrective action.	Minimal - Areas of deficiency identified during annual audits resulted in corrective action plans. Results of ongoing monitoring for several subcontractors was not provided; it is not clear whether corrective actions are in place in response to regular	Full	This requirement is addressed in the Oversight of Delegated Subcontractors Policy. Areas of deficiency were identified during annual audit results and	

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	reporting for these entities. ASH was assessed penalties as described above. **MCO Response:** Please see corrective action plan monitoring for ASH and Avesis.		corrective action plans (CAPs) were given to ASH, Triad, Avesis and McKesson. Ongoing monitoring was provided by regular meetings, at least quarterly, with the subcontractors as evidenced by meeting minutes provided by CCKY for Avesis, Triad, McKesson and ASH.	
E. If the Contractor delegates selection of providers to another entity, the Contractor retains the right to approve, suspend, or terminate any provider selected by that Subcontractor.				
F. The Contractor shall assure that the Subcontractor is in compliance with the requirement in 42 CFR 438.	Minimal - See sub-elements above. **MCO Response:** Please see corrective action plan monitoring for ASH and Avesis.	Full	This requirement is addressed in the Oversight of Delegated Subcontractors Policy. Ongoing monitoring was provided by regular meetings, at least quarterly, with the subcontractors as evidenced by meeting minutes provided by CCKY for Avesis, Triad, McKesson and ASH.	
7.1 Subcontractor Indemnity				
Except as otherwise provided in this Contract, all Subcontracts between the Contractor and its Subcontractors, shall contain an agreement by the Subcontractor to indemnify, defend and hold				

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
harmless the Commonwealth, its officers, agents, and employees, and each and every Member from any liability whatsoever arising in connection with this Contract for the payment of any debt of or the fulfillment of any obligation of the Subcontractor.				
Each such Subcontractor shall further covenant and agree that in the event of a breach of the Subcontract by the Contractor, termination of the Subcontract, or insolvency of the Contractor, each Subcontractor shall provide all services and fulfill all of its obligations pursuant to the Subcontract for the remainder of any month for which the Department has made payments to the Contractor, and shall fulfill all of its obligations respecting the transfer of Members to other Providers, including record maintenance, access and reporting requirements all such covenants, agreements, and obligations of which shall survive the termination of this Contract and any Subcontract.				
7.2 Requirements				
All Subcontractors must be eligible for participation in the Medicaid program as applicable. The Contractor may, with the approval of the Department, enter into Subcontracts for the provision of various Covered Services to Members or other services that involve risk-sharing, medical management, or otherwise interact with a Member. Each such Subcontract				

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and any amendment to such Subcontract shall be in writing, and in form and content approved by the Department. The Contractor shall submit for review to the Department a template of each type of such Subcontract referenced herein. The Department may approve, approve with modification, or reject the templates if they do not satisfy the requirements of this Contract. In determining whether the Department will impose conditions or limitations on its approval of a Subcontract, the Department may consider such factors as it deems appropriate to protect the Commonwealth and Members, including but not limited to, the proposed Subcontractor's past performance. In the event the Department has not approved a Subcontract referenced herein prior to its scheduled effective date, Contractor agrees to execute said Subcontract contingent upon receiving the Department's approval. No Subcontract shall in any way relieve the Contractor of any responsibility for the performance of its duties pursuant to this Contract. The Contractor shall notify the Department in writing of the status of all Subcontractors on a quarterly basis and of the termination of any approved Subcontract within ten (10) days following termination.				
The Department's subcontract review shall assure that all Subcontracts:				
A. Identify the population covered by the Subcontract;				

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. Specify the amount, duration and scope of services to be provided by the Subcontractor;				
C. Specify procedures and criteria for extension, renegotiation, and termination;				
D. Specify that Subcontractors use only Medicaid providers in accordance with this Contract;				
E. Make full disclosure of the method of compensation or other consideration to be received from the Contractor;				
F. Provide for monitoring by the Contractor of the quality of services rendered to Members in accordance with the terms of this Contract;				
G. Contain no provision that provides incentives, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services;				
H. Contain a prohibition on assignment, or on any further subcontracting, without the prior written consent of the Department;				
I. Contain an explicit provision that the Commonwealth is the intended third-party beneficiary of the Subcontract and, as such, the Commonwealth is entitled to all remedies entitled to third-party beneficiaries under law;				
J. Specify that Subcontractor where applicable, agrees to submit Encounter Records in the format specified by the Department so that the Contractor can meet the Department's specifications required				

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
by this Contract;				
K. Incorporate all provisions of this Contract to the fullest extent applicable to the service or activity delegated pursuant to the Subcontract, including, without limitation,				
(1) the obligation to comply with all applicable federal and Commonwealth law and regulations, including, but not limited to, KRS 205:8451-8483, all rules, policies and procedures of Finance and the Department, and all standards governing the provision of Covered Services and information to Members,				
(2) all QAPI requirements,				
(3) all record keeping and reporting requirements,				
(4) all obligations to maintain the confidentiality of information,				
(5) all rights of Finance, the Department, the Office of the Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and Commonwealth agents to inspect, investigate, monitor and audit operations,				
(6) all indemnification and insurance requirements, and				
(7) all obligations upon termination;				
L. Provide for Contractor to monitor the				

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Subcontractor's performance on an ongoing basis including those with accreditation: the frequency and method of reporting to the Contractor; the process by which the Contractor evaluates the Subcontractor's performance; and subjecting it to formal review according to a periodic schedule consistent with industry standards, but no less than annually;				
M. A Subcontractor with NCQA/URAC or other national accreditation shall provide the Contractor with a copy of its' current certificate of accreditation together with a copy of the survey report.	Substantial - 7/8 of contracts are compliant. NCQA certificate for VSP expired 5/3/12. **Recommendation for Coventry Cares** Current accreditation certificates and survey reports should be maintained for each subcontractor.	Full	URAC accreditation and survey reports were provided for: ASH and Express Scripts. NCQA accreditation and survey reports were provided for: NIA, MHNet, McKesson, and Triad. Avesis is not accredited.	
N. Provide a process for the Subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action.				
O. The remedies up to, and including, revocation of the subcontract available to the Contractor if the Subcontractor does not fulfill its obligations.				
P. Contain provisions that suspected fraud and abuse be reported to the contractor.				
Section 7.2 requirements would be applicable to Subcontractors characterized as Providers/Risk Arrangements including, but not limited to, physicians, hospitals, ancillary providers, IPAs/PHOs, Provider Networks, and Vision Care,				

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Dental and Behavior Health Services; and to those who interact and assist Members including, but not limited to, Radiology Benefit Manager, Disease Management/Case Management, Health Risk Assessments, Pre-Certification Services, PBM, Recoveries, Translation Services and 24-hour Section 7.2 requirements shall not apply to Subcontracts for administrative services or other vendor contracts that do not impact Members.				
7.3 Disclosure of Subcontractors				
The Contractor shall inform the Department of any Subcontractor providing Covered Services which engages another Subcontractor in any transaction or series of transactions, in performance of any term of this Contract, which in one fiscal year exceeds the lesser of $25,000 or five percent (5%) of the Subcontractor's operating expense.	Non-Compliance - Coventry Cares did not address this requirement in the documentation provided. **MCO Response:** CoventryCares of Kentucky has requested annual disclosure of ownership (ADO) information from its Subcontractors. Additionally, COM-006 Delegated Vendor Oversight policy has been updated to address. ADOs that have been received to date are included.	Substantial	No evidence of an update to the Oversight Policy is evidenced. The Policy provided makes no mention to the reporting requirement levied on the Contractor nor does it include any of the state contractual language. The Annual Disclosure of Ownership information has been provided from each of CCKY's subcontractors. **Recommendation for CCKY** The Oversight Policy should be updated to address disclosure of subcontractors to DMS.	The Oversight Policy is on the Policies and Procedures agenda for an update to reflect the disclosure of subcontractors to DMS.
7.4 Remedies				
Finance shall have the right to invoke against any Subcontractor any remedy set forth in this Contract, including the right to require the				

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
termination of any Subcontract, for each and every reason for which it may invoke such a remedy against the Contractor or require the termination of this Contract.				

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	5	1	0	0
Total Points	15	2	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.83**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services Suggested Evidence

Documents

List of subcontractors including type(s) of services provided and date of initial delegation
Contract with each subcontractor
Accreditation certificate and report for each subcontractor
Policies and procedures for subcontractor oversight
Subcontractor Oversight Committee description, meeting agendas and minutes
Documentation of ongoing oversight of subcontractors including follow-up
List of subcontractors terminated during the period of review
Evidence of DMS notification of all new subcontractors and terminated subcontractors
Evidence of disclosure of subcontractor activity to DMS

Reports

Pre-delegation evaluation report for new subcontractors
Periodic, formal evaluation reports for each subcontractor, including those with accreditation
Subcontractor certificate of accreditation and survey report

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CoventryCares of Kentucky (CCKY)
Quality Assessment and Performance Improvement: Health Information Systems (HIS) (2014)

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Quality Assessment and Performance Improvement: Health Information Systems (HIS) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
17.1 Encounter Data Submission				
The Contractor shall have a computer and data processing system sufficient to accurately produce the data, reports and Encounter Record set in formats and timelines prescribed by the Department as defined in the Contract.		Full	Policy and Procedure CSO - 002 Claims Processing addresses this. A Business Associate Amendment was also provided for their vendor McKesson.	
The system shall be capable of following or tracing an Encounter within its system using a unique Encounter Record identification number for each Encounter.		Full	Policy and Procedure CSO - 002 Claims Processing addresses this. A Business Associate Amendment was also provided for their vendor McKesson.	
At a minimum, the Contractor shall be required to electronically provide Encounter Record to the Department, on a weekly schedule.		Full	Policy ENC-001 (formerly GEN004) addresses this contract requirement.	
Encounter Record must follow the format, data elements and method of transmission specified by the Department.		Full	Policy ENC-001 (formerly GEN004) addresses this contract requirement.	
All changes to edits and processing requirements due to Federal or State law changes shall be provided to the Contractor in writing no less than sixty (60) working days prior to implementation, whenever possible.				
The Contractor shall submit electronic test data files as required by the Department in the format referenced in this Contract and as specified by the Department.		Not Applicable	No evidence provided that the Department has requested test data files.	
The electronic test files are subject to Department review and approval before production of data.				
The Contractor shall have the capacity to track and		Full	Policy ENC-001 (formerly GEN004)	

Quality Assessment and Performance Improvement: Health Information Systems (HIS) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
report on all Erred Encounter Records.			addresses this contract requirement. "Report YYYYMM_rejects_skips_not reconciled" show how erred records are tracked.	
The Contractor shall be required to use procedure codes, diagnosis codes and other codes used for reporting Encounter Record in accordance with guidelines defined by the Department in writing. The Contractor must also use appropriate NPI/Provider numbers for Encounter Records as directed by the Department.		Full	Policy ENC-001 (formerly GEN004) addresses this contract requirement. Standard HIPAA file formats are used.	
All subcontracts with Providers or other vendors of service must have provisions requiring that Encounter Record is reported/submitted in an accurate and timely fashion.		Full	Addressed in provider and subcontractor agreements.	
The Contractor shall specify to the Department the name of the primary contract person assigned responsibility for submitting and correcting Encounter Record, and a secondary contact person in the event the primary contract person is not available.		Full	CCKY provided meeting minutes for the 8/7/13 and 8/15/13 meetings showing MCO attendance.	
17.2 Technical Workgroup				
The Contractor shall assign staff to participate in the Encounter Technical Workgroup periodically scheduled by the Department. The workgroup's purpose is to enhance the data submission requirements and improve the accuracy, quality and completeness of the Encounter Record.		Full	CCKY provided example meeting minutes for the 8/7/13 and 8/15/13 meetings showing MCO attendance. During interview, CCKY reported attendance at each call.	
18 Kentucky Health Information Exchange (KHIE)				

Quality Assessment and Performance Improvement: Health Information Systems (HIS) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall provide all adjudicated Claims data within twenty-four (24) hours of final claim adjudication in support of KHIE. The Contractor shall provide the KHIE with all clinical data as soon as it is available. The Contractor will also share with the KHIE any Member patient clinical data.		Not Applicable	The requirement to submit to KHIE was suspended by KDMS in March 2013. Although the requirements were suspended, the MCO shall make a good faith effort to encourage all providers in their network to establish connectivity with the KHIE.	
The PCPs in the Contractor's network shall be required to connect to KHIE within one (1) year of the effective date of the contract with the Contractor or other schedule as determined by the Department. Furthermore, the Contractor shall encourage all providers in their Network to establish connectivity with the KHIE.		Not Applicable	The requirement to submit to KHIE was suspended by KDMS in March 2013. Although the requirements were suspended, the MCO shall make a good faith effort to encourage all providers in their network to establish connectivity with the KHIE.	
29.1 Claims Payments				
In accordance with the Balanced Budget Act (BBA) Section 4708, the Contractor shall implement Claims payment procedures that ensure 90% of all Provider Claims for which no further written information or substantiation is required in order to make payment are paid or denied within thirty (30) days of the date of receipt of such Claims and that 99% of all Claims are processed within ninety (90) days of the date of receipt of such Claims.		Full	Addressed in P/Ps: ENC-001, CSO-001 (Claims Payment Timeliness) and CSO-002 (Claims Processing). The Operational Performance Reports for 2013 demonstrate compliance with meeting the 30 days standard.	
In addition, the Contractor shall comply with the Prompt-Pay statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and 99-123, as may be amended.		Full	Policy CSO - 001 Claims Payment Timeliness addresses this requirement. In addition, the Provider Manual chapter B Claim Payments and Processing Time Frames was provided. Report showing prompt pay was also provided.	

Quality Assessment and Performance Improvement: Health Information Systems

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	11	0	0	0
Total Points	33	0	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average	3.0			

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable	Statement does not require a review decision

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Quality Assessment and Performance Improvement: Health Information Systems
Suggested Evidence

Documents

Policies/procedures for:

- Claims processing
- Claims payment
- Encounter data reporting

Process for verifying the accuracy and completeness of provider and vendor reported data
Process for screening data for completeness, logic and consistency
Evidence of timely and accurate reporting of encounter data to DMS
Process for monitoring compliance with claims payment timeliness requirements
Process for tracking and reporting erred encounter records
Evidence of participation in Encounter Technical workgroup
Method for meeting KHIE requirements
Status of efforts to have PCPs establish connectivity to KHIE

Reports

Timeliness of Claims Payment
Results of compliance monitoring for timeliness of claims payment and compliance with prompt pay statute
Internal quality measurement results related to accuracy and completeness of encounter data, including analysis and follow-up

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CoventryCares of Kentucky (CCKY)
Case Management/Care Coordination (2014)

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
2. Definitions				
Care Coordination means the integration of all processes in response to a Member's needs and strengths to ensure the achievement of desired outcomes and the effectiveness of services.				
Care Management System includes a comprehensive assessment and care plan care coordination and case management services. This includes a set of processes that arrange, deliver, monitor and evaluate care, treatment and medical and social services to a member.				
Care Plan means written documentation of decisions made in advance of care provided, based on a Comprehensive Assessment of a Member's needs, preference and abilities, regarding how services will be provided. This includes establishing objectives with the Member and determining the most appropriate types, timing and supplier(s) of services. This is an ongoing activity as long as care is provided.				
Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.				
Children with Special Health Care Needs means				

Case Management/Care Coordination *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Members who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount that is beyond that required by children generally and who may be enrolled in a Children with Special Health Care Needs program operated by a local Title V funded Maternal and Child Health Program.				
CHIPRA means the Children's Health Insurance Program Reauthorization Act of 2009 which reauthorized the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. It assures that State is able to continue their existing program and expands insurance coverage to additional low-income, uninsured children.				
Comprehensive Assessment means the detailed assessment of the nature and cause of a person's specific conditions and needs as well as personal resources and abilities. This is generally performed by an individual or a team of specialists and may involve family, or other significant people. The assessment may be done in conjunction with care planning.				
34.2 Care Management System				
As part of the Care Management System, Contractor shall employ care coordinators and case managers to arrange, assure delivery of, monitor and evaluate basic and comprehensive care, treatment and services to a Member.				

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Members needing Care Management Services shall be identified through the health risk assessment, evaluation of Claims data, Physician referral or other mechanisms that may be utilized by the Contractor.				
The Contractor shall develop guidelines for Care Coordination that will be submitted to the Department for review and approval. The Contractor shall have approval from the Department for any subsequent changes prior to implementation of such changes.				
Care coordination shall be linked to other Contractor systems, such as QI, Member Services and Grievances.	**Non-Compliance** - Linkage of care coordination with other contractor systems not addressed in the policies provided. **MCO Response:** The current policy (UM-004) has been updated to reflect the on-going coordination of care activities related to quality of care, quality of service, grievances and appeals, case management referrals, adverse events and member service inquiries. Initial policies were prospective based on the start-up nature of the health plan. Processes have evolved as the plan has	Full	CCKY indicated that P/P UM-004 had been replaced by P/P CM-035. CCKY provided this policy during the onsite review. CM-035 Continuity and Coordination of Care states that CM, Concurrent Review, Customer Service, and Prior Authorization teams arrange clinical services and work with the member to ensure a physician is selected to coordinate services to address the member's needs. In the interview, CCKY indicated that all grievances, UM activities, and concerns for the DCBS population are routed to the DCBS lead for management. Linkage to the MCO's quality	

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	matured. Please see the revised UM-004 policy as attached.		improvement program is demonstrated via the DCBS Satisfaction Survey to evaluate satisfaction with coordination of care. This is a new process therefore; there were no data to share.	
34.3 Care Coordination				
The care coordinators and case managers will work together with the primary care providers as teams to provide appropriate services for Members.				
Care coordination is a process to assure that the physical and behavioral health needs of the Members are identified and services are facilitated and coordinated with all service providers, individual Members and family, if appropriate, and authorized by the Member.				
The Contractor shall identify the primary elements for care coordination and submit the plan to the Department for approval.				
The Contractor shall identify a Member with special health care needs, including but not limited to Members identified in Member Services. A Member with special health care needs shall have a Comprehensive Assessment completed upon admission to a Care Management program. The Member will be referred to Care Management. Guidelines for referral to the appropriate care management programs shall be pre-approved by the Department. The guidelines will also include the criteria for development of				

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Care Plans. The Care Plan shall include both appropriate medical, behavioral and social services and be consistent with the Primary Care Provider's clinical treatment plan and medical diagnosis.				
The Contractor shall first complete a Care Coordination Assessment for these Members the elements of which shall comply with policies and procedures approved by the Department.				
The Care Plan shall be developed in accordance with 42 CFR 438.208.				
The Contractor shall develop and implement policies and procedures to ensure access to care coordination for all DCBS clients. The Contractor shall track, analyze, report, and when indicated, develop corrective action plans on indicators that measure utilization, access, complaints and grievances, and satisfaction with care and services specific to the DCBS population.	**Non-Compliance** - Coventry provided Report 65, Foster Care Report as evidence. This report provides information on members in foster care including enrollment in case management, and disease management, completion of health risk assessments. It does not address measurement of utilization, access, complaints and grievances and satisfaction for this population. **MCO Response:** CM-011 has been updated to reflect utilization, access, complaints and grievances as well as	Non-Compliance	The plan submitted CM-011 (Case Management for Members in Foster Care and Members Receiving Adoption Services) P/P. This document outlines the procedures to ensure access to care coordination for all DCBS clients. The plan also submitted CM-010 (Access to Special Needs Providers) P/P which outlines procedures to ensure appropriate and timely access to providers, particularly for Individuals with Special Health Care Needs (ISHCN). UM-017 (Monitoring of Over and Under Utilization) described how the plan will collect, review, analyze and report on utilization data to assess performance as well as the	The plan has created a specific population based measure for analysis and comparison to other populations. These measures will allow CoventryCares of KY to confirm access to coordination of care for all DCBS clients. Eligible populations will be identified for both ISHCN members, and a comparable population of members of similar age. Metrics for measures such as annual dental visits, well child visits, adolescent well care and access to PCP's will be tracked for both groups. Secondly, these measures will be compared between the ISHCN and overall populations. A statistical T-test for variation of means will be performed using the sample sizes for each measure. In instances where the ISHCN population

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	satisfaction. Please also see Policy UM-004, CM-010 and UM-017.		performance of network providers and how this performance impacts the quality of care and well being of members. This P/P is a general policy, and not specific to the DCBS population. After the last audit, the plan stated that they updated CM-011 to address noted deficiencies; however, this P/P still does not address deficiencies, nor did the plan provide evidence to show how they track, analyze, report, and develop corrective action plans on indicators that measure utilization, access, complaints and grievances, and satisfaction with care and services specific to the DCBS population. In the interview, CCKY indicated that all grievances, UM activities, and concerns for the DCBS population are routed to the DCBS lead for management. This addresses the tracking and actions for individual DCBS members related to access to care and complaints and the like. CCKY provided a process for evaluating satisfaction of child members in foster care. This is a new process to be implemented so there are no data at present.	shows a statistically significant decrease (at the 95% confidence interval level) in care coordination than the population at large, plans for corrective action will be created to address the discrepancy in care for ISHCN clients. For the "control" group population, we will select a large (>500) random set of members from the general population of enrollees who are between the ages of 12 months and 19 years of age as of December 31 of the measurement year. Metrics will be applied identically to this population and the ISHCN population. The ISHCN population will be defined as the child and adolescent enrollees, in the SSI and Foster categories of aid, and those who received services from the Commission for Children with Special Health Care Needs (CCSHCN), who received the specified services related to access to care and preventive care, as defined in the HEDIS specifications. The outline of the measurement procedure/steps is attached as KY PM 2014 CSCHN_Access_Preventive_Care_Final_Rev_7-10-2014.docx.

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			However, the survey addresses satisfaction only - it does not address population-based measurement and analysis of utilization, access, complaints and grievances for the DCBS population. Care Coordination File Review 10 files were reviewed. 8/10 included a comprehensive assessment and care plan; for the 2 remaining files – one opted out of care coordination and the other has no needs identified. Complex Case Management File Review 10 of 10 files reviewed included a comprehensive assessment, care plan, identification of physical and behavioral health needs, and facilitation and coordination of services. **Recommendation for CCKY** CCKY should track specific population-based measures for analysis and comparison to other populations. Stratifying measures across the member populations would satisfy this requirement. CCKY could examine the rates for the KY performance measures related to ISCHN (access to PCPs, well	

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			child visits, etc.) and implement actions for improvement where warranted. Other measures could include: utilization of ED, inpatient, primary care, dental and other services to identify potential gaps on a population-level.	
Members, Member representatives and providers shall be provided information relating to care management services, including case management, and information on how to request and obtain these services.				
35.1 Individuals with Special Health Care Needs (ISHCN)				
ISHCN are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISCHN may have an increased need for healthcare or related services due to their respective conditions. The primary purpose of the definition is to identify these individuals so the Contractor can facilitate access to appropriate services.				
As per the requirement of 42 CFR 438.208, the Department has defined the following categories of individuals who shall be identified as ISHCN. The Contractor shall have written policies and procedures in place which govern how Members				

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
with these multiple and complex physical and behavioral health care needs are further identified.				
The Contractor shall have an internal operational process, in accordance with policy and procedure, to target Members for the purpose of screening and identifying ISHCN's.				
The Contractor shall assess each member identified as ISHCN in order to identify any ongoing special conditions that require a course of treatment or regular care monitoring. The assessment process shall use appropriate health professionals.				
The Contractor shall employ reasonable efforts to identify ISHCN's based on the following populations: Children in/or receiving Foster Care or adoption assistance; Blind/Disabled Children under age 19 and Related Populations eligible for SSI; Adults over the age of 65; Homeless (upon identification); individuals with chronic physical health illnesses; and individuals with chronic behavioral health illnesses.				
The Contractor shall develop and distribute to ISHCN Members, caregivers, parents and/or legal guardians, information and materials specific to the needs of the member, as appropriate. This information shall include health educational material as appropriate to assist ISHCN and/or caregivers in understanding their chronic illness.				

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State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall have in place policies governing the mechanisms utilized to identify, screen, and assess individuals with special health care needs.				
The Contractor will produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring.				
The Contractor shall develop practice guidelines and other criteria that consider that needs of ISHCN and provide guidance in the provision of acute and chronic physical and behavioral health care services to this population.				
35.2 DCBS Protection and Department for Aging and Independent Living DAIL Protection and Permanency Clients				
Members who are adult guardianship clients or foster care children shall be identified as ISHCN and shall be enrolled in the Contractor through a service plan that will be completed on each such Member by DCBS and Department for Aging and Independent Living (DAIL) prior to being enrolled with the Contractor. The service plan will be completed by DCBS or DAIL and forwarded to the Contractor prior to Enrollment and will be used by DCBS and or DAIL and the Contractor to determine the individual's medical needs and identify the need for placement in case management. The Contractor shall be responsible for the ongoing care coordination of these members whether or	**Minimal** - Addressed in P/P CM 017. Reports 65 and 66 provided. DCBS Service Plan File Review Coventry Cares reports ongoing efforts to obtain service plans for DCBS and DAIL clients and to coordinate care for these members. Receipt of service plans and ongoing communication with DCBS has been inconsistent and this inconsistency was noted	Substantial	Addressed in P/P CM-017. CCKY submitted the following reports: 1. Foster Care active as of 1-29-14 with ME codes.xlsx 2. Care coordination listing 7-1-13 thru 12-31-13 with codes.xlsx In the onsite interview, CCKY indicated that P/P FIN-001 Reporting Timeframes addresses monthly reporting of Foster Care Cases, specifically, Report #65 Foster Care and Report #66 Guardianship.	The plan will continue to communicate and meet with DCBS on a regular basis. Each month the plan attends the Liaison Meetings with delegates from DCBS, DMS, CRP, and MHNET to address concerns as illustrated below. Dates of Liaison Meetings and agenda items covered during the First Quarter 2014: • 01/23/2014(Telephonic) In attendance: Representatives from the Department for Community Based Services,

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
not enrolled in case management to ensure access to needed social, community, medical and behavioral health services. A monthly report of Foster Care Cases shall be sent to Department thirty (30) days after the end of each month.	in the files reviewed. Of 20 files reviewed, service plans were provided in 11 files. When service plans were provided, the MCO used the information to determine the member's medical needs and to identify members for case management services. Regardless of provision of a service plan, files reviewed demonstrated ongoing care coordination, when appropriate. <u>DCBS Claims File Review</u> IPRO also conducted a claims review of DCBS members: all professional/outpatient claims, documentation of outreach efforts including outreach related to EPSDT services, and any case management or care coordination files for selected members were requested. Twenty files were reviewed with the following results: 13 of 20 files included evidence of at least one well visit during the review		<u>DCBS Service Plan File Review</u> IPRO conducted a review of DCBS Services Plans. A total of 12 files were reviewed. 4 of 12 had no DCBS signature 9 of 12 had no MCO signature 1 of 12 cases demonstrated use of the service plan to identify the member's medical needs and need for CM. 10 of 12 cases demonstrated ongoing coordination of care with DCBS. There was documentation of many attempts by the CM to reach the DCBS worker. 1 of 12 cases had documentation of need for and referral to CM. 8 of 12 cases demonstrated monthly meeting of CM/DCBS to coordinate and address the needs of the child. CCKY indicated that it was difficult to reach the DCBS workers in many cases and that the MCO DCBS liaison has been aggressive in efforts to obtain service plans. This has been particularly challenging due to the large number of service areas/counties and DCBS offices. Often service plans are sent to CCKY from DCBS, and therefore, there is no MCO signature on the Service Plan. CCKY provided meeting logs which evidenced regular meetings with DCBS.	Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet Discussed: Foster Care Service Plans, Supports to Children with Complex Needs, Behavioral Health de-certifications, Individual Member issues • 02/27/2014 (Telephonic): In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet Discussed: Foster Care Service Plans, SSI de-certifications, Barriers to Assisting Members, Individual Member Issues • 03/27/2014 (Telephonic): In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet Discussed: Foster Care Service Plans, Satisfaction Surveys, Barriers

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	period. Of the remaining 7 files, 4 files lacked evidence of a well visit and 3 files were not applicable (2 members were not due for a well visit and one member was hospitalized in a NICU). Of the 13 files including a well visit, provision of EPSDT services was evident in 12 files (one file - claims did not show evidence of an EPSDT service code). Outreach efforts were not evident in the 5 files lacking a well visit and/or EPSDT service claim. Care coordination was evident in 7 files reviewed. The remaining 13 files did not require care coordination services. **MCO Response:** Please see Policy CM-017 which has been updated to reflect the process for obtaining services plans for DCBS and DAIL clients.		Files showed a lot of back and forth via voicemail for the MCO CM to reach the DCBS worker. The CM files were well-documented and showed evidence of ongoing identification of needs, referrals and linkage, care coordination, and follow-up where necessary. <u>DCBS Claims File Review</u> IPRO also conducted a claims review of DCBS members: all professional/outpatient claims, documentation of outreach efforts including outreach related to EPSDT services, and any case management or care coordination. The files did not contain claims data. CCKY did provide this via ftp posting. Claims were reviewed offsite after the onsite review. Ten files were reviewed with the following results: 9 of 10 files included evidence of at least one well visit during the review period. 9 of 10 files evidenced EPSDT services provided. 1 of 1 file evidenced outreach for lack of EPSDT services.	to Assisting Members, Discharge Planning and individual member issues • 04/24/2014 (Face to Face): In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet Discussed: Foster Care Service Plans, Supports to Children with Complex Needs, Behavioral Health de-certifications, Individual Member issues • 05/22/2014 (Face to Face): In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet Discussed: Foster Care Service Plans, SSI de-certifications, Barriers to Assisting Members, Individual Member Issues • June meeting was cancelled per the state.

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	The plan's Foster Care liaison began requesting missing service plans on 6-5-13 as part of each conversation with DCBS. When the DCBS liaison calls the plan with a foster care child or adoption services child issue, the plan Foster Care liaison requests the service plan. Calls from the DCBS liaison are typically those that are escalated to the plan for immediate resolution. These members are the ones who are mostly likely to have a completed service plan. A meeting with DCBS occurred on 6/20/13. During the meeting, Coventry Cares requested DCBS schedule monthly meetings to discuss and sign off on service plans. Claim specific to EPSDT service code for one file was located in the Navigator system. Evidence is enclosed. EPSDT outreach includes reminders for needed EPSDT visits with the provider. The		3 of 3 files evidenced coordination of PH and BH services. 10 of 10 files showed coordination between providers and services. For the one member who did not have any well visits or EPSDT services, the CM noted a history of non-compliance and did conduct outreach for EPSDT services. Of note: CCKY has developed and is using an excellent tracking sheet which includes: Program Status, Category Code, medically fragile, date of contact initiation, number of attempts to contact DCBS, permission from DCBS to contact foster parent, screening tool completed, acute needs addressed, benefits questions addressed, referrals/resources provided, mailed information sent, therapies, need for coordination of therapies during school breaks, enrollment in First Steps or CM, member not enrolled in CM/case closed, member not enrolled in CM/follow-up call scheduled, ESPDT special services, reason member not enrolled in CM, conference calls, incoming calls from DCBS/foster parent.	

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	letters are automatically uploaded to the Navigator system. See enclosed documentation for original dates of outreach.		**Recommendation for CCKY** CCKY should continue its efforts to obtain Service Plans and to meet with DMS and DCBS staff to establish effective information-sharing protocols.	
35.3 Adult Guardianship Clients				
Upon Enrollment with the Contractor, each adult in Guardianship shall have a service plan prepared by DAIL. The service plan shall indicate DAIL level of responsibility for making medical decisions for each Member. If the service plan identifies the need for case management, the Contractor shall work with Guardianship staff and/or the Member, as appropriate, to develop a case management care plan.	**Non-Compliance** - P/P CM 017 indicates that individual in adult guardianship have separate policies, however these were not provided for review. **MCO Response:** Policy CM-012 has been revised and is enclosed for review. The updated policy will be presented to the Policies & Procedure Committee for review and approval.	Full	Addressed in P/P CM-017 (Case Management of Persons with Special Needs) and CM-012 (Case Management for Adult Guardianship).	
35.4 Children in Foster Care				
Upon Enrollment with the Contractor, each child in Foster Care shall have a service plan prepared by DCBS. DCBS shall forward a copy of the service plan to the Contractor on each newly enrolled Foster Care child. No less than monthly, DCBS staff shall meet with Contractor's staff to identify, discuss and resolve any health care issues and needs of the child as identified in the service plan.	**Minimal -** Addressed in P/P CM 011. DCBS Service Plan File Review Coventry Cares reports ongoing efforts to obtain service plans for DCBS and DAIL clients and to	Substantial	Addressed in P/P CM-011 (Case Management for Members in Foster Care and Members Receiving Adoption Services) and CM – 017 (Case Management of Persons with Special Needs). As noted above, CCKY makes diligent efforts to obtain Service Plans for all foster children who are	The plan will continue to communicate and meet with DCBS on a regular basis. Each month the plan attends the Liaison Meetings with delegates from DCBS, DMS, CRP, and MHNET to address concerns as illustrated below. Dates of Liaison Meetings and agenda

Case Management/Care Coordination *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Examples of these issues include needed specialized Medicaid Covered Services, community services and whether the child's current primary and specialty care providers are enrolled in the Contractor's Network.	coordinate care for these members. Receipt of service plans and ongoing communication with DCBS has been inconsistent and this inconsistency was noted in the files reviewed. Of 20 files reviewed, service plans were provided in 11 files. When service plans were provided, the MCO used the information to determine the member's medical needs and to identify members for case management services. Coventry Cares should continue to work with DCBS to obtain timely, complete service plans and to establish regular communications (e.g., monthly meetings) to discuss the needs of individual DCBS members. **MCO Response:** Please see Policy CM-017 which has been updated to reflect the process for obtaining service plans for DCBS and DAIL clients. The plan's Foster Care liaison began requesting missing		members. CCKY provided logs to demonstrate regular meetings with DCBS. See element 35.2 above for detailed information. <u>DCBS Service Plan File Review</u> 4 of 12 had no DCBS signature 9 of 12 had no MCO signature 1 of 12 cases demonstrated use of the service plan to identify the member's medical needs and need for CM. See element 35.2 above for further detail. **<u>Recommendation for CCKY</u>** CCKY should continue its efforts to obtain Service Plans and meet with and coordinate with DMS and DCBS staff.	items covered during the First Quarter 2014: • 01/23/2014(Telephonic) In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet Discussed: Foster Care Service Plans, Supports to Children with Complex Needs, Behavioral Health de-certifications, Individual Member issues • 02/27/2014 (Telephonic): In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet Discussed: Foster Care Service Plans, SSI de-certifications, Barriers to Assisting Members, Individual Member Issues • 03/27/2014 (Telephonic): In attendance: Representatives from the Department for Community Based Services,

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	service plans on 6-5-13 as part of each conversation with DCBS. When the DCBS liaison calls the plan with a foster care child or adoption services child issue, the plan Foster Care liaison requests the service plan. Calls from the DCBS liaison are typically those that are escalated to the plan for immediate resolution. These members are the ones who are mostly likely to have a completed service plan. A meeting with DCBS occurred on 6/20/13. During the meeting, CoventryCares requested DCBS schedule monthly meetings to discuss and sign off on service plans.			Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet Discussed: Foster Care Service Plans, Satisfaction Surveys, Barriers to Assisting Members, Discharge Planning and individual member issues • 04/24/2014 (Face to Face): In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet Discussed: Foster Care Service Plans, Supports to Children with Complex Needs, Behavioral Health de-certifications, Individual Member issues • 05/22/2014 (Face to Face): In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet Discussed: Foster Care Service

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				Plans, SSI de-certifications, Barriers to Assisting Members, Individual Member Issues • June meeting was cancelled per the state.
If DCBS service plan identifies the need for case management or DCBS staff requests case management for a Member, the foster parent and/or DCBS staff will work with Contractor's staff to develop a case management care plan.	NA - Addressed in P/P CM 017 and CM 011. DCBS Service Plan File Review None of the files reviewed required case management services.	Full	Addressed in P/P CM-011 (Case Management for Members in Foster Care and Members Receiving Adoption Services) and CM – 017 (Case Management of Persons with Special Needs). DCBS Service Plan File Review Only one file evidenced the need for CM services and was referred for CM. See element 35.2 above for further detail.	
The Contractor will consult with DCBS staff before the development of a new case management care plan (on a newly identified health care issue) or modification of an existing case management care plan.	NA - Addressed in P/P CM 011. DCBS Service Plan File Review None of the files reviewed required case management services.	Full	Addressed in P/P CM-011 (Case Management for Members in Foster Care and Members Receiving Adoption Services) and CM – 017 (Case Management of Persons with Special Needs). DCBS Service Plan File Review The CM files were well-documented and showed evidence of ongoing identification of needs, referrals and linkage, care coordination, and follow-	

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			up where necessary.	
The DCBS and designated Contractor staff will sign each service plan to indicate their agreement with the plan. If the DCBS and Contractor staff cannot reach agreement on the service plan for a Member, information about that Member's physical health care needs, unresolved issues in developing the case management plan, and a summary of resolutions discussed by the DCBS and Contractor staff will be forwarded to the designated county DCBS worker. That DCBS staff member shall work with the designated Contractor representative and a designated Department representative, if needed, to agree on a service plan. If agreement is not reached through mediation, the service plan shall be referred to the Department for resolution through the appeals process.	**Minimal -** Addressed in P/P CM 011. <u>DCBS Service Plan File Review</u> Coventry Cares reports ongoing efforts to obtain service plans for DCBS and DAIL clients and to coordinate care for these members. Receipt of service plans and ongoing communication with DCBS has been inconsistent and this inconsistency was noted in the files reviewed. Of 20 files reviewed, service plans were provided in 11 files. When service plans were provided, the MCO used the information to determine the member's medical needs and to identify members for case management services. Coventry Cares should continue to work with DCBS to obtain timely, complete service plans and to establish regular communications (e.g., monthly meetings) to discuss the needs of	Substantial	Partially addressed in P/P CM-011 (Case Management for Members in Foster Care and Members Receiving Adoption Services). P/P documents do not address cases where the DCBS and CM staff cannot reach an agreement on the service plan for a Member, i.e. that the case will be forwarded to the designated county DCBS worker, that the case might be referred to mediation or DMS for resolution. In the interview, CCKY indicated that P/P CM-011 would be updated to address situations where CCKY and DCBS cannot reach an agreement on the Service Plan/CM enrollment. <u>DCBS Service Plan File Review</u> IPRO conducted a review of DCBS Services Plans. A total of 12 files were reviewed. 4 of 12 had no DCBS signature 9 of 12 had no MCO signature As indicated prior, CCKY has a designated DCBS liaison, is diligent in efforts to obtain Service Plans, and has arranged to meet regularly with DCBS	The following language has been added to CM-011 and sent for review to the Policy and Procedure Committee for approval: If the DCBS staff and the plans Foster Care/Subsidized Adoption Case Manager Liaison cannot reach agreement on the service plan for a member, information about that member's physical health care needs, unresolved issues in developing the case management plan, and a summary of resolutions discussed by the DCBS staff and Foster Care/Subsidized Adoption Case Manager Liaison will be forwarded to the designated county DCBS worker. The DCBS staff member shall work with the plans Foster Care/Subsidized Adoption Case Manager Liaison and a designated Department representative, if needed, to agree on a service plan. If the agreement is not reached through mediation, the service plan shall be referred to the Department for resolution through the appeals process.

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	individual DCBS members. **MCO Response:** Please see Policy CM-011 which has been updated to reflect the process for obtaining services plans for DCBS and DAIL clients. The plan's Foster Care liaison began requesting missing service plans on 6-5-13 as part of each conversation with DCBS. When the DCBS liaison calls the plan with a foster care child or adoption services child issue, the plan Foster Care liaison requests the service plan. Calls from the DCBS liaison are typically those that are escalated to the plan for immediate resolution. These members are the ones who are mostly likely to have a completed service plan. A meeting with DCBS occurred on 6/20/13. During the meeting, CoventryCares requested DCBS schedule monthly meetings to discuss and sign off on service plans.		staff. If a Service Plan is received in other than a DCBS/CCKY meeting, it will not have an MCO signature. **Recommendation for CCKY** P/P CM-011 should be updated to address situations where CCKY and DCBS cannot reach an agreement on the Service Plan/CM enrollment.	
35.5 Children Receiving Adoption Assistance				

Case Management/Care Coordination *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Upon Enrollment with the Contractor, each Member receiving adoption assistance shall have a service plan prepared by DCBS. The process for enrollment of children receiving adoption assistance shall follow that outlined for Children in Foster Care.	**Minimal -** Addressed in P/P CM 017 and CM 011. <u>DCBS Service Plan File Review</u> Coventry Cares reports ongoing efforts to obtain service plans for DCBS and DAIL clients and to coordinate care for these members. Receipt of service plans and ongoing communication with DCBS has been inconsistent and this inconsistency was noted in the files reviewed. Of 20 files reviewed, service plans were provided in 11 files. When service plans were provided, the MCO used the information to determine the member's medical needs and to identify members for case management services. Coventry Cares should continue to work with DCBS to obtain timely, complete service plans and to establish regular communications (e.g., monthly meetings) to discuss the needs of individual DCBS members.	Full	Addressed in P/P CM-017 and CM-011. <u>DCBS Service Plan File Review</u> A total of 12 files were reviewed. There was a Service Plan for each file reviewed.	

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	MCO Response: The Prior Authorization Request Form has been updated to request the actual IEP form. (Enclosed) The plan's Foster Care liaison began requesting missing service plans on 6-5-13 as part of each conversation with DCBS. When the DCBS liaison calls the plan with a foster care child or adoption services child issue, the plan Foster Care liaison requests the service plan. Calls from the DCBS liaison are typically those that are escalated to the plan for immediate resolution. These members are the ones who are mostly likely to have a completed service plan. A meeting with DCBS occurred on 6/20/13. During the meeting, Coventry Cares requested DCBS schedule monthly meetings to discuss and sign off on service plans. See revised CM-011 and CM-017. (Enclosed)			
32. 9 Pediatric Sexual Abuse Examination				

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Contractor shall have Providers in its network that have the capacity to perform a forensic pediatric sexual abuse examination. This examination must be conducted for Members at the request of the DCBS.				
32.8 Pediatric Interface				
The Contractor shall establish procedures to coordinate care for children receiving school-based services and early intervention services, in a manner that prevents duplication of Contractor provided services. The Contractor shall monitor the continuity and coordination of care for these children as part of its QAPI program. Services provided under these programs are authorized under the Federal Individuals with Disabilities Education Act, but typically excluded from Contractor coverage except in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services. IEP services should not be duplicated.	**Substantial** - Addressed in P/P CM 017 although not explicit regarding coverage during interruptions. **Recommendation for Coventry Cares** P/P CM 017 should be revised to address coverage during interruptions.	Full	Addressed in P/P CM-017. CCKY has created a tracking tool in which receipt of First Steps and school-based services is documented. Additionally, the tracking tool indicates that continuity for school-based services will be needed during school breaks. The file(s) for which this was applicable evidenced efforts to maintain continuity of school-based services during school breaks.	
School-Based Services provided by schools are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid when provided by a Medicaid enrolled provider. School-Based Services provided by public health departments are included in Contractor coverage. However, in situations where a child's	Substantial - Addressed in P/P CM 017 although not explicit regarding coverage/responsibilities during interruptions. **Recommendation for**	Full	Addressed in P/P CM-017. The policy states: For pediatric members enrolled in case management and receiving school based services, the case manager will coordinate care for any interruptions in school based	

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services. Coordination between the schools and the Contractor shall ensure that Members receive medically necessary services that complement the individual education plan (IEP) services and promote the highest level of function for the child.	**Coventry Cares** P/P CM 017 should be revised to address coverage during interruptions.		services.	
The Contractor shall coordinate services between the First Steps program and Contractor coverage. The First Steps program is an entitlement program established by the Federal Individuals with Disabilities Education Act (IDEA) and is funded by federal, state and local funds. The goal of the program is to provide early intervention services to children from birth up to age three who have developmental disabilities or delays. The intended outcome of the program is to ensure maximum amelioration of the impact of developmental disabilities or delays on infants and toddlers by early and ongoing provision of rehabilitation services.				
In order for Contractor and its Providers to effectively manage care for Members who qualify for these services, it will be necessary to coordinate the care provided through both programs as children who are receiving these services are identified, to share information with early intervention/school-based service providers with appropriate permission from parents.	Substantial - Addressed in P/P CM 017 although does not explicitly address parental permission. **Recommendation for Coventry Cares** P/P CM 017 should be	Full	Addressed in P/P CM-017.	

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	revised to address parental permission.			
Services provided under HANDS shall be excluded from Contractor coverage. HANDS is a home visitation program for first-time parents. It services children under three (3) years of age and it promotes good parenting skills.				
37.11 DCBS and DAIL Service Plans Reporting				
Thirty (30) days after the end of each quarter, the Contractor shall submit a quarterly report detailing the number of service plan reviews conducted for Guardianship, Foster and Adoption assistance Members outcome decisions, such as referral to case management, and rationale for decisions.				

Case Management/Care Coordination/Department for Community Based Services (DCBS) Clients

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	8	3	0	1
Total Points	24	6	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.73**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Case Management/Care Coordination
Suggested Evidence

Documents

Policies/Procedures for:

- Identification of members for care management services
- Care coordination
- Comprehensive Assessment including guidelines for referral to care management programs
- Care Plan including criteria for care plan development
- ISHCN including identification, screening and assessment
- DCBS and DAIL clients
- Coordination of care for children receiving school-based services and early intervention services
- Pediatric sexual abuse examination
- Measurement of utilization, access, complaint and grievance, and satisfaction data for DCBS population.

Case manager and care coordinator position descriptions
Evidence of dissemination of information to members, member representatives and providers relating to care management services
Evidence of monitoring effectiveness of case management
Evidence of tracking, analysis, reporting and interventions for indicators measuring utilization, access, complaints and grievances, and satisfaction with care and services for DCBS population
Evidence of dissemination of information and materials specific to the needs of the ISHCN member
Evidence of practice guidelines or other criteria considering the needs of ISHCN

Reports

Monthly/quarterly reports of service plan reviews conducted for DCBS and DAIL clients
Number of DCBS and DAIL clients enrolled in the MCO as of the last day of the review period (December 31, 2013)
Number of DCBS and DAIL clients enrolled in the MCO who are enrolled in case management/care coordination as of the last day of the review period (December 31, 2013)
Monthly reports of Foster Care cases

File Review

Care Coordination files for a random sample of cases selected by EQRO
Logs of DCBS/MCO and DAIL/MCO meetings to review members
DCBS and DAIL Service Plans for a sample of cases selected by EQRO
DCBS Case Management files/claims records

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CoventryCares of Kentucky (CCKY)
Enrollee Rights and Protection: Enrollee Rights (2014)

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Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
22.6 Member Rights and Responsibilities				
The Contractor shall have written policies and procedures that are designed to protect the rights of Members and enumerate the responsibilities of each Member. A written description of the rights and responsibilities of Members shall be included in the Member information materials provided to new Members.				
A copy of these policies and procedures shall be provided to all of the Contractor's Network Providers to whom Members may be referred. In addition, these policies and procedures shall be provided to any Out-of-Network Provider upon request from the Provider.	Substantial - During the on-site visit, the MCO advised that the member's rights and responsibilities are located on the Website and are accessible to all out-of-network providers. **Recommendation for Coventry Cares** The MCO should include in its policies/procedures the method for providing this policy to out-of network providers.	Substantial	Member rights and responsibilities are included in the Provider Manual and are available on the MCO website. A policy/procedure for describing the MCO's method for communicating this information to out of network providers was not evident in the documents provided. Onsite: CCKY noted that the provider manual is available on the MCO website to out of network providers. **Recommendation for CCKY** The MCO should include in its policies/procedures the method for providing this policy to out-of network providers.	The contract language specifically requires CCKY to provide member rights and responsibilities policies to any Out-of-Network Provider **upon request** from the provider. Any requests received by a provider, by any means, including through the Provider Call Center, is provided to them and providers are referred to the MCO website where it is easily accessible.
The Contractor's written policies and procedures that are designed to protect the rights of Members shall include, without limitation, the right to:				
A. Respect, dignity, privacy, confidentiality and nondiscrimination;				

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;				
C. Consent for or refusal of treatment and active participation in decision choices;				
D. Ask questions and receive complete information relating to the Member's medical condition and treatment options, including specialty care;				
E. Voice Grievances and receive access to the Grievance process, receive assistance in filing an Appeal, and receive a state fair hearing from the Contractor and/or the Department;				
F. Timely access to care that does not have any communication or physical access barriers;				
G. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;				
H. Assistance with Medical Records in accordance with applicable federal and state laws;				
I. Timely referral and access to medically indicated specialty care; and				
J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.				
The Contractor shall also have policies addressing the responsibility of each Member to:				
A. Become informed about Member rights:				
B. Abide by the Contractor's and Department's policies and procedures;				

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
C. Become informed about service and treatment options;				
D. Actively participate in personal health and care decisions, practice healthy life styles;				
E. Report suspected Fraud and Abuse; and				
F. Keep appointments or call to cancel.				
22.2 Member Handbook				
The Contractor shall publish a Member Handbook and make the handbook available to Members upon enrollment, to be delivered to the Member within five (5) business days of Contractor's notification of Member's enrollment. Contractor is in compliance with this requirement if the Member's handbook is mailed within five (5) business days by a method that will not take more than three (3) days to reach the Member.				
The Member Handbook shall be available in English, Spanish and any other language spoken by five (5) percent of the potential enrollee or enrollee population.				
The Member Handbook shall be available in a hardcopy format as well as an electronic format online.				
The Contractor shall review the handbook at least annually and shall communicate any changes to Members in written form. Revision dates shall be added to the Member Handbook so that it is evident which version is the most current. Changes shall be approved by the Department prior to printing. The Department has the authority to review the Contractor's Member Handbook at any time.				
The handbook shall be written at the sixth grade reading				

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
comprehension level and shall include at a minimum the following information:				
A. The Contractor's Network of Primary Care Providers, including a list of the names, telephones numbers, and service site addresses of PCPs available for Primary Care Providers in the network listing. The network listing may be combined with the Member Handbook or distributed as a stand-alone document;				
B. The procedures for selecting a PCP and scheduling an initial health appointment;				
C. The name of the Contractor and address and telephone number from which it conducts its business; the hours of business; and the Member Services telephone number and twenty-four/seven (24/7) toll-free medical call-in system;				
D. A list of all available Covered Services, an explanation of any service limitations or exclusions from coverage and a notice stating that the Contractor will be liable only for those services authorized by the Contractor;				
E. Member rights and responsibilities including reporting suspected fraud and abuse;				
F. Procedures for obtaining Emergency Care and non-emergency after hours care. For a life-threatening situation, instructs Members to use the emergency medical services available or to activate emergency medical services by dialing 911;				
G. Procedures for obtaining transportation for both emergency and non-emergency situations;				
H. Information on the availability of maternity, family planning and sexually transmitted disease services and				

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
methods of accessing those services;				
I. Procedures for arranging EPSDT for persons under the age of 21 years;				
J. Procedures for obtaining access to Long Term Care Services;				
K. Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;				
L. A list of direct access services that may be accessed without the authorization of a PCP;				
M. Information about procedures for selecting a PCP or requesting a change of PCP and specialists; reasons for which a request may be denied; reasons a Provider may request a change;				
N. Information about how to access care before a PCP is assigned or chosen;				
O. A Member's right to obtain second opinion and information on obtaining second opinions related to surgical procedures, complex and/or chronic conditions;				
P. Procedures for obtaining Covered Services from non-network providers;				
Q. Procedures for filing a Grievance or Appeal. This shall include the title, address, and telephone number of the person responsible for processing and resolving Grievances and Appeals;				
R. Information about the Cabinet for Health and Family Services' independent ombudsman program for Members;				

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
S. Information on the availability of, and procedures for obtaining behavioral health/substance abuse health services;				
T. Information on the availability of health education services;				
U. Information deemed mandatory by the Department; and				
V. The availability of care coordination, case management and disease management provided by the Contractor.				
30.3 Second Opinions				
The Contractor shall provide for a second opinion related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions within the Contractor's network, at the Member's request. The Contractor shall inform the Member, in writing, at the time of Enrollment, of the Member's right to request for a second opinion.				
22.1 Required Functions				
The Contractor shall have a Member Services function that includes a call center which is staffed and available by telephone Monday through Friday 7 am to 7 pm Eastern Standard Time (EST). The call center shall meet the current American Accreditation Health Care Commission/URAC-designed Health Call Center Standard (HCC) for call center abandonment rate, blockage rate and average speed of answer. If a Contractor has separate telephone lines for different Medicaid populations, the Contractor shall report performance for each individual line separately. The Department will				

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
inform the Contractor of any changes/updates to these URAC call center standards.				
The Contractor shall also provide access to medical advice and direction through a centralized toll-free call-in system, available twenty-four (24) hours a day, seven (7) days a week nationwide. The twenty-four/seven (24/7) call-in system shall be staffed by appropriately trained medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses (LPN), and registered nurses (RNs).				
The Contractor shall self-report their prior month performance in the three areas listed above, call center abandonment rate, blockage rate and average speed of answer, for their member services and twenty-four/seven (24/7) hour toll-free medical call-in system to the Department.				
Appropriate foreign language interpreters shall be provided by the Contractor and available free of charge and as necessary to ensure availability of effective communication regarding treatment, medical history, or health education. Member materials shall be provided and printed in each language spoken by five (5) percent or more of the Members in each county. The Contractor staff shall be able to respond to the special communication need of the disabled, blind, deaf and aged and effectively interpersonally relate with economically and ethnically diverse populations. The Contractor shall provide ongoing training to its staff and Providers on matters related to meeting the needs of economically disadvantaged and culturally diverse individuals.				

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall require that all Service Locations meet the requirements of the Americans with Disabilities Act, Commonwealth and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures applicable to health care facilities. The Contractor shall cooperate with the Cabinet for Health and Family Services' independent ombudsman program, including providing immediate access to a Member's records when written Member consent is provided.				
The Contractor's Member Services function shall also be responsible for:				
A. Ensuring that Members are informed of their rights and responsibilities;	Non-Compliance - Coventry Cares did not provide a policy and procedure for Member Services Functions. The MCO advised that the functions are listed in the training manual. **MCO Response:** New Policy MC-016 Member Services Functions has been drafted. (Enclosed) It will be reviewed and approved by the Policies & Procedures Committee.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe. **Recommendation for CCKY** Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
B. Monitoring the selection and assignment process of PCPs;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe. **Recommendation for CCKY** Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	
C. Identifying, investigating, and resolving Member Grievances about health care services;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe. **Recommendation for CCKY** Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
D. Assisting Members with filing formal Appeals regarding plan determinations;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services,	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			dated 2/27/14 which addresses this requirement but is outside the timeframe. **Recommendation for CCKY** Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	
E. Providing each Member with an identification card that identifies the Member as a participant with the Contractor, unless otherwise approved by the Department;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe. **Recommendation for CCKY** Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
F. Explaining rights and responsibilities to members or to those who are unclear about their rights or responsibilities including reporting of suspected fraud and abuse;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			requirement but is outside the timeframe. **Recommendation for CCKY** Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	
G. Explaining Contractor's rights and responsibilities, including the responsibility to assure minimal waiting periods for scheduled member office visits and telephone requests, and avoiding undue pressure to select specific Providers or services;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe. **Recommendation for CCKY** Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
H. Providing within five (5) business days of the Contractor being notified of the enrollment of a new Member, by a method that will not take more than three (3) days to reach the Member, and whenever requested by member, guardian or authorized representative, a Member Handbook and information on how to access services; (alternate notification methods shall be available for persons who have reading difficulties or visual impairments);	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for CCKY Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	
I. Explaining or answering any questions regarding the Member Handbook;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe. **Recommendation for CCKY** Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
J. Facilitating the selection of or explaining the process to select or change Primary Care Providers through telephone or face-to-face contact where appropriate. The Contractor shall assist members to make the most appropriate Primary Care Provider selection based on previous or current Primary Care Provider relationship, providers of other family members, medical history, language needs, provider location and other factors that are important to the Member. The Contractor shall notify members within thirty (30) days prior to the effective	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
date of voluntary termination (or if Provider notifies Contractor less than thirty (30) days prior to the effective date, as soon as Contractor receives notice), and within fifteen (15) days prior to the effective date of involuntary termination if their Primary Care Provider leaves the Program and assist members in selecting a new Primary Care Provider;			**Recommendation for CCKY** Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	
K. Facilitating direct access to specialty physicians in the circumstances of: (1) Members with long-term, complex health conditions; (2) Aged, blind, deaf, or disabled persons; and (3) Members who have been identified as having special healthcare needs and who require a course of treatment or regular healthcare monitoring. This access can be achieved through referrals from the Primary Care Provider or by the specialty physician being permitted to serve as the Primary Care Provider.	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe. **Recommendation for CCKY** Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
L. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of twenty-one (21) years;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for CCKY Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	
M. Providing Members with information or referring to support services offered outside the Contractor's Network such as WIC, child nutrition, elderly and child abuse, parenting skills, stress control, exercise, smoking cessation, weight loss, behavioral health and substance abuse;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe. **Recommendation for CCKY** Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
N. Facilitating direct access to primary care vision services; primary dental and oral surgery services, and evaluations by orthodontists and prosthodontists; women's health specialists; voluntary family planning; maternity care for Members under age 18; childhood immunizations; sexually transmitted disease screening, evaluation and treatment; tuberculosis screening, evaluation and treatment; and testing for HIV, HIV-related conditions and other communicable diseases; all as further described in Appendix I of this Contract;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe. **Recommendation for CCKY**	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	
O. Facilitating access to behavioral health services and pharmaceutical services;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe. **Recommendation for CCKY** Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
P. Facilitating access to the services of public health departments, Community Mental Health Centers, rural health clinics, Federally Qualified Health Centers, the Commission for Children with Special Health Care Needs and charitable care providers, such as Shriner's Hospital for Children;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe. **Recommendation for CCKY** Policy/procedure should address member	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	
Q. Assisting members in making appointments with Providers and obtaining services. When the Contractor is unable to meet the accessibility standards for access to Primary Care Providers or referrals to specialty providers, the Member Services staff function shall document and refer such problems to the designated Member Services Director for resolution;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe. **Recommendation for CCKY** Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
R. Assisting members in obtaining transportation for both emergency and appropriate non-emergency situations;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe. **Recommendation for CCKY** Policy/procedure should address member services functions as noted in the MCO's	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			contract with DMS. The 2014 policy/procedure addresses the requirement.	
S. Handling, recording and tracking Member Grievances properly and timely and acting as an advocate to assure Members receive adequate representation when seeking an expedited Appeal;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe. **Recommendation for CCKY** Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
T. Facilitating access to Member Health Education Programs;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe. **Recommendation for CCKY** Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			policy/procedure addresses the requirement.	
U. Assisting members in completing the Health Risk Assessment (HRA) as outlined in **Covered Services** upon any telephone contact; and referring Members to the appropriate areas to learn how to access the health education and prevention opportunities available to them including referral to case management or disease management; and	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe. **Recommendation for CCKY** Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
V. The Member Services staff shall be responsible for making an annual report to management about any changes needed in Member Services functions to improve either the quality of care provided or the method of delivery. A copy of the report shall be provided to the Department.	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents. After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe. **Recommendation for CCKY** Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			requirement.	
30.4 Billing Members for Covered Services				
The Contractor and its Providers and Subcontractors shall not bill a Member for Medically Necessary Covered Services with the exception of applicable co-pays or other cost sharing requirements provided under this contract. Any Provider who knowingly and willfully bills a Member for a Medicaid Covered Service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act. This provision shall remain in effect even if the Contractor becomes insolvent.				
However, if a Member agrees in advance in writing to pay for a Non-Medicaid covered service, then the Contractor, the Contractor's Provider, or Contractor's Subcontractor may bill the Member. The standard release form signed by the Member at the time of services does not relieve the Contractor, Providers and Subcontractors from the prohibition against billing a Medicaid Member in the absence of a knowing assumption of liability for a Non-Medicaid covered Service. The form or other type of acknowledgement relevant to the Medicaid Member liability must specifically state the services or procedures that are not covered by Medicaid.				
22.9 Choice of Providers				
Dual Eligible Members, Members who are presumptively eligible, disabled children, and foster care children are not required to have a PCP. All other Members in the MCO must choose or have the Contractor select a PCP for their medical home.				
The Contractor shall have two processes in place for				

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Members to choose a PCP: (A) a process for Members who have SSI coverage but are not Dual Eligible Members, and (B) a process for other Members.				
23.4 PCP Changes				
The Contractor shall have written policies and procedures for allowing Members to select or be assigned to a new PCP when such change is mutually agreed to by the Contractor and Member, when a PCP is terminated from coverage, or when a PCP change is as part of the resolution to an Appeal.				
The Contractor shall allow the Members to select another PCP within ten (10) days of the approved change or the Contractor shall assign a PCP to the Member if a selection is not made within the timeframe.				
A member shall have the right to change the PCP 90 days after the initial assignment and once a year regardless of reason, and at any time for any reason as approved by the Member's Contractor. The Member may also change the PCP if there has been a temporary loss of eligibility and this loss caused the Member to miss the annual opportunity, if Medicaid or Medicare imposes sanctions on the PCP, or if the Member and/or the PCP are no longer located in the Contractor's Region.				
The Member shall also have the right to change the PCP at any time for cause. Good cause includes the Member was denied access to needed medical services; the Member received poor quality of care; and the Member does not have access to providers qualified to treat his or her health care needs. If the Contractor approves the Member's request, the assignment will occur no later than first day of the second month following the month				

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
of the request.				
PCPs shall have the right to request a Member's Disenrollment from his/her practice and be reassigned to a new PCP in the following circumstances: incompatibility of the PCP/patient relationship or inability to meet the medical needs of the Member.				
PCPs shall not have the right to request a Member's Disenrollment from their practice for the following: a change in the Member's health status or need for treatment; a Member's utilization of medical services; a Member's diminished mental capacity; or, disruptive behavior that results from the Member's special health care needs unless the behavior impairs the ability of the PCP to furnish services to the Member or others. Transfer requests shall not be based on race, color, national origin, handicap, age or gender. The Contractor shall have authority to approve all transfers.				
The initial Provider must serve until the new Provider begins serving the Member, barring ethical or legal issues. The Member has the right to Appeal such a transfer in the formal Appeals process. The Provider shall make the change for request in writing. Member may request PCP change in writing, face to face or via telephone.				
The Contractor shall provide written notice within fifteen (15) days to a member whose PCP has been voluntarily or involuntarily disenrolled or been terminated from participation in the Contractor's network.				
30.5 Referral for Non-covered Contractor Services				
When it is necessary for a Member to receive a Medicaid service that is outside the scope of the contract, the				

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Contractor shall refer the Member to a provider enrolled in the Medicaid fee-for-service program. The Contractor shall have written policies and procedures for the referral of Member for Non-Covered services that shall provide for the transition to a qualified health care provider and, where necessary, assistance to Members in obtaining a new Primary Care Provider. The Contractor shall submit any desired changes to the established written referral policies and procedures to the Department for review and approval.				

Enrollee Rights and Protection: Enrollee Rights

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance

Points Value	**3**	**2**	**1**	**0**
Number of Elements	0	1	0	22
Total Points	0	2	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average				.09

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Enrollee Rights and Protection: Enrollee Rights
Suggested Evidence

Documents

Policies/Procedures for:

- Member rights and responsibilities

- Choice of providers
- PCP changes
- Referral for non-covered services provided by FFS Medicaid providers
- Second Opinions
- Required member services functions including, but not limited to, call center and medical call-in system
- Cost Sharing

Member Handbook including any separate inserts or materials
Sample Member newsletters and other informational materials
Sample Provider newsletters and other informational materials
Provider Manual or evidence demonstrating that policies/procedures related to member rights and responsibilities are communicated to providers
Sample of member notifications of voluntary and involuntary PCP termination
Evidence of provision of Member Handbook within five business days of notification of enrollment

Reports
Census information on common ethnicities and languages other than English spoken by 5% or more of the enrolled population in a county
Annual Member Services Report
Call center metrics
Medical call-in system metrics

CoventryCares of Kentucky (CCKY)
Medical Records (2014)

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Medical Records *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
38.1 Medical Records				
Member Medical Records if maintained by the Contractor shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.				
The Contractor shall have medical record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA. The Contractor shall protect Member information from unauthorized disclosure as set forth in Confidentiality of Records of this Agreement.				
The Contractor shall conduct HIPAA				

Medical Records *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
privacy and security audits of providers as prescribed by the Department.				
The Contractor shall include provisions in its Subcontracts for access to the Medical Records of its Members by the Contractor, the Department, the Office of the Inspector General and other authorized Commonwealth and federal agents thereof, for purposes of auditing. Additionally, Provider contracts shall provide that when a Member changes PCP, the Medical Records or copies of Medical Records shall be forwarded to the new PCP or Partnership within ten (10) Days from receipt of request. The Contractor's PCPs shall have Members sign a release of Medical Records before a Medical Record transfer occurs.	Substantial - P/P UM – 031 Clinical Record Confidentiality addresses confidentiality. The following contracts address this requirement: VSP- Section 7.5 Medical Records Access to Records – Section 7.6 Inspection and Audits of Records Section 7.4 Medco - Section 9 Pharmacy Records Transition Period Records – Section 6 Avesis-Section 9 Medical Records Transfer of Medical Records Access to Records and Audits, Number 4 ASH-Section 2.18 & Section 9 Business Associate Agreement – Number 8 NIA-Medical Records Section 7 Access to Records, Section 8 MHNet-Access to Medical Records - Section IV Access to Medical Records for Inspection – Section IV Access to Records Transfer of Records – Article III, Section 3.3.	Full	This requirement is addressed in the Provider Manual. When a member changes their PCP; the previous PCP will forward, at no cost to the plan or member, the member's medical records within 10 days of request to the member's new PCP. The transfer of medical records to a new PCP is addressed in the Provider Manual under Records Management.	

Medical Records *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Recommendation for Coventry Cares The contracts should include a provision for when a member changes PCPs, e.g., the medical records or copies of medical records shall be forwarded to the new PCP within ten (10) Days from receipt of request and the Contractor's PCPs shall have members sign a release of medical records before a medical record transfer occurs.			
The Contractor shall have a process to systematically review provider medical records to ensure compliance with the medical records standards. The Contractor shall institute improvement and actions when standards are not met. The Contractor shall have a mechanism to assess the effectiveness of practice-site follow-up plans to increase compliance with the Contractor's established medical records standards and goals.				
The Contractor shall develop methodologies for assessing performance/compliance to medical record standards of PCP's/PCP sites, high risk/high volume specialist, dental providers, providers of ancillaries services not less than				

Medical Records *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
every three (3) years. Audit activity shall, at a minimum:				
A. Demonstrate the degree to which providers are complying with clinical and preventative care guidelines adopted by the Contractor;				
B. Allow for the tracking and trending of individual and plan wide provider performance over time;				
C. Include mechanism and processes that allow for the identification, investigation and resolution of quality of care concerns; and				
D. Include mechanism for detecting instances of over-utilization, under-utilization, and miss utilization.	Non-Compliance - Evidence of a process for detecting instances of over-utilization, under-utilization, and miss utilization was not provided. **MCO Response:** Please see policy UM-017 enclosed and the Program Integrity Plan. Both documents address monitoring over and under utilization of services.	Full	The following document addresses this requirement: UM - 017 Monitoring of over under utilization.	
27.6 Medical Records				
The Contractor shall require their Providers to maintain Member medical records on paper or in an electronic format. Member Medical Records shall be maintained timely,				

Medical Records *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.				
The Member's Medical Record is the property of the Provider who generates the record. However, each Member or their representative is entitled to one free copy of his/her medical record. Additional copies shall be made available to Members at cost. Medical records shall generally be preserved and maintained for a minimum of five (5) years unless federal requirements mandate a longer retention period (i.e. immunization and tuberculosis records are required to be kept for a person's lifetime).				

Medical Records *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall ensure that the PCP maintains a primary medical record for each member, which contains sufficient medical information from all providers involved in the Member's care, to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:				
A. Member/patient identification information, on each page;				
B. Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, identify language spoken and guardianship information;				
C. Date of data entry and date of encounter;				
D. Provider identification by name;				
E. Allergies, adverse reactions and any known allergies shall be noted in				

Medical Records *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
a prominent location;				
F. Past medical history, including serious accidents, operations, and illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (i.e. documentation of chickenpox);				
G. Identification of current problems;				
H. The consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering provider's initials or other documentation indicating review;				
I. Documentation of immunizations pursuant to 902 KAR 2:060;				
J. Identification and history of nicotine, alcohol use or substance abuse;				
K. Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2:020;				
L. Follow-up visits provided secondary to reports of emergency				

Medical Records *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
room care;				
M. Hospital discharge summaries;				
N. Advanced Medical Directives, for adults;				
O. All written denials of service and the reason for the denial; and				
P. Record legibility to at least a peer of the writer. Any record judged illegible by one reviewer shall be evaluated by another reviewer.				
A Member's medical record shall include the following minimal detail for individual clinical encounters:				
A. History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status;	Substantial - The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements. The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements. The medical record documentation audit tool states "identification of current problems, significant illnesses, and medical/psychological condition should be indicated on the Problem List/or progress note." Physical examination is	Substantial	The Provider Manual states that the CCKY Providers are responsible for maintaining records according to the state and federal requirements. Specifically it is addressed in the section on Medical Record Documentation Standards. As noted last year, the medical record documentation audit tool states "identification of current problems, significant illnesses, and medical/psychological condition should be indicated on the Problem List/or progress note." Physical examination is	The medical record documentation audit for 2014 has been completed. The medical documentation tool will be updated to reflect this change and will be implemented to capture the physical examination requirements outlined for this recommendation- to be effective for the 2015 audit.

Medical Records *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	not included in the tool. **Recommendation for Coventry Cares** Audit tool for medical record documentation should include all required elements.		not included in the tool. **Recommendation for CCKY** Provider Manual, audit tool and guidelines in P/P #QI-015 (Medical Record Documentation Review) should be consistent and include all required elements in the contract.	
B. Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits; and				
C. Plan of treatment including: 1. Medication history, medications prescribed, including the strength, amount, directions for use and refills; and 2. Therapies and other prescribed regimen; and 3. Follow-up plans including consultation and referrals and directions, including time to return.	Substantial - The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements. The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements. The medical record documentation audit tool includes medication history but does not address medications prescribed, including the strength, amount, directions for use and refills; or therapies and other prescribed regimen. Follow-up plans are addressed.	Substantial	This is addressed in the Provider Manual in the section on Medical Record Documentation Standards. As noted last year, the medical record documentation audit tool includes medication history but does not address medications prescribed, including the strength, amount, directions for use and refills; or therapies and other prescribed regimen. Follow-up plans are addressed. **Recommendation for CCKY** Provider Manual, audit tool and	The medical record documentation audit for 2014 has been completed. The medical documentation tool will be updated to reflect this change and will be implemented to capture the medication requirements outlined for this recommendation- to be effective for the 2015 audit.

Medical Records *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Recommendation for Coventry Cares Audit tool for medical record documentation should include all required elements.		guidelines in P/P #QI-015 (Medical Record Documentation Review) should be consistent and include all required elements in the contract.	
27.7 Advance Medical Directives				
The Contractor shall comply with laws relating to Advance Medical Directives pursuant to KRS 311.621 – 311.643 and 42 CFR Part 489, Subpart I and 42 CFR 422.128, 438.6 and 438.10 Advance Medical Directives, including living wills or durable powers of attorney for health care, allow adult Members to initiate directions about their future medical care in those circumstances where Members are unable to make their own health care decisions.				
The Contractor shall, at a minimum, provide written information on Advance Medical Directives to all Members and shall notify all Members of any changes in the rules and regulations governing Advance Medical Directives within ninety (90) Days of the change and provide information to its PCPs via the Provider Manual and Member Services staff on informing Members about Advance Medical Directives.				

Medical Records *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
PCPs have the responsibility to discuss Advance Medical Directives with adult Members at the first medical appointment and chart that discussion in the medical record of the Member.				
38.2 Confidentiality of Records				
The parties agree that all information, records, and data collected in connection with this Contract, including Medical Records, shall be protected from unauthorized disclosure as provided in 42 CFR Section 431, subpart F, KRS 194.060A, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the laws specified in Section 40.12.				
The Contractor shall have written policies and procedures for maintaining the confidentiality of Member information consistent with applicable laws. Policies and procedures shall include, but not be limited to, adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction,				

Medical Records *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. The policies and procedures shall also address such issues as how to contact the minor Member for any needed follow-up and limitations on telephone or mail contact to the home.				
The Contractor on behalf of its employees, agents and assigns, shall sign a confidentiality agreement.				.
Except as otherwise required by law, regulations or this contract, access to such information shall be limited by the Contractor and the Department to persons who or agencies which require the information in order to perform their duties related to the administration of the Department, including, but not limited to, the US Department of Health and Human Services, U.S. Attorney's Office, the Office of the Inspector General, the Office of the Attorney General, and such others as may be required by the Department.				
40.12 Health Insurance Portability and Accountability Act				

Medical Records *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor agrees to abide by the rules and regulations regarding the confidentiality of protected health information as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164. Any Subcontract entered by the Contractor as a result of this agreement shall mandate that the subcontractor be required to abide by the same statutes and regulations regarding confidentiality of protected health information as is the Contractor.				

Medical Records

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	2	2	0	0
Total Points	6	4	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.5**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Medical Records
Suggested Evidence

Documents

Policies/procedures for:

- Confidentiality/HIPAA
- Access to medical records
- Transfer of records
- Medical records and documentation standards
- Process and tools for assessing/monitoring provider compliance with medical record standards including performance goals
- Advance Medical Directives

Sample contracts between MCO and network providers and subcontractors demonstrating provisions for medical records and documentation standards; and confidentiality/HIPAA requirements
Member materials related to Advance Directives
Provider materials related to Advance Directives
Evidence of signed confidentiality agreement on behalf of employees, agents and assigns

Reports

Provider compliance assessment/monitoring results and follow-up

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CoventryCares of Kentucky (CCKY)
Behavioral Health Services (2014)

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Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
33.3 General Behavioral Health Requirements				
The Department requires the Contractor's provision of mental health services to be recovery and resiliency focused. This means that services will be provided to allow individuals, or in the case of, a minor, family or guardian, to have the greatest opportunities for decision making and participation in the individual's treatment and rehabilitation plans.				
33.4 Covered Behavioral Health Services				
The Contractor shall assure the provision of all Medically Necessary Behavioral Health Services for Members. These services are described in Appendix I.				
All Behavioral Health services shall be provided in conformance with the access standards established by the Department. When assessing Members for BH Services, the Contractor and its providers shall use the DSM-IV multi-axial classification. The Contractor may require use of other diagnostic and assessment instrument/outcome measures in addition to the DSM-IV.				
Providers shall document DSM-IV diagnosis and assessment/outcome information in the Member's medical record.				
33.5 Behavioral Health Provider Network				
The Contractor must emphasize utilization				

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
management, assuring the services authorized are provided, are medically necessary and produce positive health outcomes. The Department and DBHDID will coordinate on the requirement of data collection and reporting to assure that state and federal funds utilized in financing behavioral health services are efficiently utilized and meet the overall goals of health outcomes.				
The Contractor shall utilize DSM-IV classification for Behavioral Health billings.				
The Contractor shall provide access to psychiatrists, psychologists, and other behavioral health service providers.				
In order to meet the provider network requirement for BH services, Community Mental Health Centers (CMHCs) located within the Contractor service region shall be offered participation in the Contractor provider network.	Substantial - Demonstrated in Geo Access reports. Coventry Cares provided Geo Access reports for July 2012 for Community Mental Health Centers. All counties were compliant with the exception of: Region 5, Madison at 65.9% for urban Region 6, Gallatin and Grant at 66.2% and 86.2% for urban. **Recommendation for Coventry Cares** The above counties did not meet access standards. This may be due to the number of CMHCs available for contracting in those counties. The MCO should clarify whether	Substantial	Addressed in Geo Access reports. All counties were compliant with the exception of: 1 Provider within 30 miles Fulton County, 55.8% for urban Livingston County, 96.9% for urban Meade County, 90.5% for urban 1 Provider within 30 minutes Henderson County 99.6% for urban Ballard County 92.4% for urban Fulton County 50.2% for urban Hancock County 40.8% for urban Henderson County 99.6% for urban	100% of the CMHCs in the Commonwealth of Kentucky are participating providers with MHNet and have been since go live on Nov. 1. 2011. All available CMHC's are being utilized. CCKY will continue to recruit providers and will continue to comply with the requirements of the Geo Access reporting.

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	all CMHCs in the region were offered participation and whether all accepted participation.		Livingston County 87.4% for urban Meade County, 79.4% for urban Trigg County, 99.6% for urban Breckinridge County, 96.8% for rural CCKY clarified that 100% of CMHCs had been offered network participation and all accepted. In the interview, CCKY/MHNet acknowledged that there are some gaps in some counties. The MCO added that starting in 2014, any licensed provider, e.g., psychologists, may participate in the BH network and this will help with access. CCKY/MHNet stated that 156 providers had been added to the network. **Recommendation for CCKY** CCKY/MHNet should continue to recruit providers and re-assess the Geo-Access.	
Network providers shall have experience serving children and adolescents, persons with disabilities, the elderly, and cultural or linguistic minorities.				
The Contractor shall ensure accessibility and availability of qualified providers to all Members in the service area pursuant to Provider Program	**Minimal** - Program capacity demonstrated in Geo Access reports. The MCO also provided a listing of credentialed behavioral	Substantial	Addressed in Geo Access reports. As noted above, access is expected to improve due to the opening of the	Starting in January 2014, CCKY began monthly surveys of the Kentucky providers. This survey addresses

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Capacity Demonstration as contained in the RFP. When necessary to meet the access standards for Behavioral Health Services for its Members, the Contractor may include in its provider network other specialty care clinic providers with comparable core services of the CMHC's.	health providers. Coventry Cares provided the MHNet Quality and Utilization Management Fourth Quarter Report dated 1/31/13 including monitoring results for provider appointment availability. The results presented include MHNet's national provider network; results for the individual Kentucky market are not available. **MCO Response:** MHNet is currently in compliance with this standard. MHNet has offered network participation to all CMHCs in KY and currently contracts with 100% of the CMHCs. Please see enclosed document for supporting information.		network to additional types of BH providers. Accessibility is addressed in these reports; however, provider availability is not measured. In the interview, CCKY/MHNet indicated that appointment availability surveys for the Kentucky market had been initiated and provided the telephone script. **Recommendation for CCKY** CCKY/MHNet should evaluate the results of the availability survey when available and take action where necessary.	appointment availability, and seeks to confirm address/phone, specialties/ages served and languages spoken. This information is reported monthly on KY Report 118.
To the extent that non-psychiatrists and other providers of Behavioral health services may also be provided as a component of FQHC and RHC services, these facilities shall be offered the opportunity to participate in the Behavioral Health network. FQHC and RHC providers can continue to provide the same services they currently provide under their licenses.				
Since the Contractors shall offer participation agreements to the Community Mental Health Centers to participate in their Behavioral Health network, should a Community Mental Health Center decline participation in the Contractor in that service area, or if the Contractor fails to				

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
meet access or any other terms and conditions of the contract the Contractor may meet its BH network requirements by offering participation to other qualified specialty care clinic providers with comparable core CMHC services.				
The Contractor shall maintain a Member education process to help Members know where and how to obtain Behavioral Health Services.				
The Contractor shall permit Members to participate in the selection of the appropriate behavioral health individual practitioner(s) who will serve them and shall provide the Member with information on accessible in-network Providers with relevant experience.				
33.6 Behavioral Health Services Hotline				
The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, toll-free throughout the Contractor's region.				
Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess, triage and address specific behavioral health emergencies.				
Emergency and crisis Behavioral Health Services may be arranged through mobile crisis teams.				

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Face to face emergency services shall be available twenty-four (24) hours a day, seven (7) days a week.				
It is not acceptable for an intake line to be answered by an answering machine.				
The Contractor shall ensure that the toll-free Behavioral Health Services Hotline meets the following minimum performance requirements for all Contractor Programs and Service Areas:				
A. Ninety-nine percent (99%) of calls are answered by the fourth ring or an automated call pick-up system;				
B. No incoming calls receive a busy signal;				
C. At least eighty percent (80%) of calls must be answered by toll-free line staff within thirty (30) seconds measured from the time the call is placed in queue after selecting an option;				
D. The call abandonment rate is seven percent (7%) or less;				
E. The average hold time is two (2) minutes or less; and				
F. The system can immediately connect to the local Suicide Hotline's telephone number and other Crisis Response Systems and have patch capabilities to 911 emergency services.				
The Contractor may operate one hotline to				

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
handle emergency and crisis calls and routine Member calls.				
The Contractor cannot impose maximum call duration limits and shall allow calls to be of sufficient length to ensure adequate information is provided to the Member.	**Minimal** - The document provided – Member Services Manual 5 does not address duration of calls. Other documents referenced – UM Manual 3.5 and Customer Service Monitoring Tool were not provided. **MCO Response:** Both the Member Services Manual and the Utilization Management Policy & Procedures were updated to reflect MHNet's current policy that there is no call limit. We have never had a limitation on call duration. Please see enclosed documentation.	Full	Addressed in updated Member Services Manual 5 (page 3).	
Hotline services shall meet Cultural Competency requirements and provide linguistic access to all Members, including the interpretive services required for effective communication.				
The Behavioral Health Services Hotline may serve multiple Contractor Programs if the Hotline staff is knowledgeable about all of the Contractor Programs. The Behavioral Health Services Hotline may serve multiple Service Areas if the Hotline staff is knowledgeable about all such Service Areas, including the Behavioral Health Provider Network in each Service Area.				
The Contractor shall conduct on-going quality assurance to ensure these standards are met.				

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated.				
If Department determines that it is necessary to conduct onsite monitoring of the Contractor's Behavioral Health Services Hotline functions, the Contractors responsible for all reasonable costs incurred by Department or its authorized agent(s) relating to such monitoring.				
33.7 Coordination between the Behavioral Health Provider and the PCP				
The Contractor shall require, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice.				
The Contractor shall provide training to network PCPs on how to screen for and identify behavioral health disorders, the Contractor's referral process for Behavioral Health Services and clinical coordination requirements for such services. The Contractor shall include training on coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health	Substantial - The Provider Orientation Education policy and procedure, and Provider Orientation Presentation provided do not explicitly address screening and identification of behavioral health disorders. **Recommendation for Coventry Cares** Provider training should address screening	Full	Addressed in PCP Newsletter 2013.	

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
interventions.	and identification of behavioral health disorders.			
The Contractor shall develop policies and procedures and provide to the Department for approval regarding clinical coordination between Behavioral Health Service Providers and PCPs.	Full - Addressed in the MHNet UM Manual and Provider Quick Reference Guide. **Recommendation for DMS** It is suggested that future annual compliance reviews include a behavioral health/physical health file review to assess coordination of physical health and behavioral health services, and compliance with behavioral health standards. **DMS Response:** DMS agrees with IPRO's recommendation. Appropriate files will be requested from each MCO for the next compliance review.	Substantial	Addressed in MHNet UM Manual, Provider Quick Reference Guide and PCP Newsletter 2013. CCKY has in place a strong PH/BH mutual referral system with specific forms to be completed. BH/PH Care Coordination File Review 10 files were reviewed 2 of 5 files evidenced a comprehensive assessment with the required components 2 of 5 files evidenced a care plan with the required components 4 of 9 files evidenced identification of the PH and BH needs of the member and facilitation and coordination of needed services 0 of 8 files evidenced follow-up/rescheduling of missed appointments 0 of 5 files for hospitalized members evidenced participation in discharge planning 0 of 10 files evidenced information sharing, other than the initial referrals from/to BH CM.	Based upon CCKY's prior relationship as separate companies, MHNet has no access to the medical side of members' records, and Health Services staff has no access to Behavioral Health. During any audit or chart review, MHNet will ensure to pull records of members who have had coordinated care (through the standard Coordination of Care process) so that CCKY can evidence our coordinated services to those members with comorbid BH and medical conditions. CCKY is currently in the process of integrating BH and Health Services to provide a holistic care model for members. Until this is fully integrated, the corresponding medical health records will need to be requested from Health Services by the reviewer to accurately reflect coordination efforts.

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Note the following: Assessment - Many members were unable to contact, however, some information was available from the PH referral form. The 2 assessments that were present were narrative/informal assessments but were very detailed. Care Plan - Many members were unable to contact. The 2 care plans that were present were narrative and informal but communicated a clear plan for the member as far as referrals and resources. Identify and Address Needs - The referral forms from PH to MHNet often contained background information on the member's PH and BH condition(s) as well as needs. As noted above, where a care plan was present, a clear plan was communicated. Missed appointments rescheduled – scheduled appointments were evident in many of the records in the notes or an authorization letter in the file. However, there was no documentation of follow-up to determine if the member kept the appointment. Discharge Planning - For the members who had an inpatient MH	

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			stay, participation in discharge planning was not seen in the files. In one case there is a notation of a "30 day plan" but details are not included. Information Sharing - Many cases ended after one outreach attempt with UTC and a letter sent or CM spoke with member with no further documented outreach conducted. It is important to note that in the interview, CCKY/MHNet indicated that the 30 day plan is a discharge plan for inpatient follow-up for the first 30 days post-discharge and was not included in the files for review. A sample was provided onsite. MHNet P/P Utilization Improvement Manual regarding discharge planning and follow-up were provided by CCKY/MHNet onsite. P/P Chapter 6 Discharge Planning and Follow-up includes (section 6.1) initiating discharge planning, arranging follow-up care, and documentation; (section 6.2) contact after discharge, assessment/provision of resources, procedure for UTC: at least 2 phone	

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			attempts, letter, and follow-up in 10 days with an additional phone attempt as well as sending an appointment reminder letter on discharge, contact with the provider(s) to confirm that the appointment was kept, and procedure for rescheduling and/or other follow-up if the appointment is not kept. P/P Chapter 4 National Service Center Utilization Improvement which states that when a CM makes a referral to a provider, the CM will contact the provider to ensure that an appointment can be made, ask the provider to call if the member does not keep the appointment, and follow-up for authorization of continued treatment where necessary. P/P Chapter 5 Managing Ongoing Care provides the procedure for initiating BH CM. This includes at least 2 phone attempts at different hours of the day, mailed letter, call attempt 10 days after the letter, and efforts to obtain alternate member contact information from providers, PH CM, and the MCO.	

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			The sample 30-day plan provided was an Intensive Care Management Plan for a member with an inpatient stay that included the assessment, care plan, follow-up plans/appointments, and follow-up contacts with member and providers. Note: A possible QOC issue was identified in the file review: The female member had been inpatient for suicidal ideation. The referral form had a notation of the member communicating that her PCP had refused to see her and she had been unable to fill her antidepressant prescription for 2 months prior to her admission. In response, the CM notes indicated that she needs a new PCP and has problems getting meds due to lock-in status. It was not clear if the member got a PCP reassignment or if she was able to obtain her medications, or if the difficulties getting her depression meds were resolved. Also, the claim that the PCP refused to see the member and she could not get her medications was not	

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			directly addressed despite that fact that the member complained she had subsequent suicidal ideation and was admitted to an inpatient facility. The member's reliability could not be determined from the case documentation, but in any case, this should have been investigated and confirmed or referred as a potential QOC issue. Note that the member may have had a 30 day plan that was not available for review onsite. In the interview, the case was discussed with the MCO and CCKY indicated that the issue would be investigated. To date, no additional information has been received. **Recommendation for CCKY** CCKY/MHNet should address the following: - Ensure that more than one outreach attempt is made for members referred for BH issues. - Ensure that when members are referred for outpatient treatment and/or appointments are scheduled, that follow-up is conducted to	

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			ensure that the member keeps the appointment. - For future file reviews, ensure that all documentation, from both PH and BH, is provided for review.	
The Contractor shall require that Behavioral Health Service Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's legal guardian's consent. Behavioral Health Providers may only provide physical health care services if they are licensed to do so. This requirement shall be specified in all Provider Manuals.				
The Contractor shall require that behavioral health Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of a Members' behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement shall be specified in all Provider Manuals.				
33.8 Follow-up after Hospitalization for Behavioral Health Services				
The Contractor shall require, through Provider contract provision, that all Members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge.				

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The outpatient treatment must occur within fourteen (14) days from the date of discharge.				
The Contractor shall ensure that Behavioral Health Service Providers contact Members who have missed appointment within twenty-four (24) hours to reschedule appointments.	**Minimal** - The MHNet UM Manual 6 indicates that case managers will contact members who have missed appointments; however a timeframe for doing so is not included in the policy. **MCO Response:** This is documented in the attached Provider Contract (Section 27) and the Provider Addendum. We have modified the Provider Quick Reference Guide to reflect this. See enclosed documents.	Substantial	Provider Quick Reference Guide (page 15) indicates a procedure must be in place to contact members who missed their appointments; however a timeframe is not indicated. **Recommendation for CCKY** CCKY/MHNet should add the 24 hour timeframe to the Provider Quick Reference Guide.	CCKY has sent a request to marketing to update the Provider Quick Reference Guide to reflect the 24 hour timeframe. CCKY is currently awaiting a timeline for completion.
33.9 Court-Ordered Services				
"Court-Ordered Commitment" means an involuntary commitment of a Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to Kentucky statutes.				
The Contractor must provide inpatient psychiatric services to Members under the age of twenty-one (21) and over the age of sixty-five (65), up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under the provisions of KRS 645, Kentucky Mental Health Act of The Unified Juvenile Code and KRS 202A, Kentucky Mental Health Hospitalization Act.				
The Contractor cannot deny, reduce or	Substantial - The Provider Quick Reference	Full	The Provider Quick Reference	

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
controvert the Medical Necessity of inpatient psychiatric services provided pursuant to a Court ordered commitment for Members under the age of twenty-one (21) or over the age of sixty-five (65). Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	Guide does not address modification or termination of services. **Recommendation for Coventry Cares** Policy should be expanded to include modification or termination of services.		Guide, Kentucky Medicaid Addendum, (page 32) addresses the CCKY/MHNet policy for coverage of court-ordered commitment for members under the age of twenty-one (21) or over the age of sixty-five (65) according to KY regulations.	
33.10 Community Mental Health Center (CMHC)				
The Contractor shall coordinate with the Community Mental Health Center (CMHC) or other qualified special health care providers, other providers of behavioral health services, and state operated or state contracted psychiatric hospitals and nursing facilities regarding admission and discharge planning, treatment objectives and projected length of stay for Members committed by a court of law to the state psychiatric hospital.				
The Contractor shall enter into a collaborative agreement with the state operated or state contracted psychiatric hospital assigned to their region in accordance with 908 KAR 3:040 and in accordance with federal Olmstead law. At a minimum the agreement shall include responsibilities of the Behavioral Health Service Provider to assure continuity of care for successful transition back into community-based supports.				
In addition, the Contractor Behavioral Health				

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Service Providers shall participate in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.				
The Contractor shall ensure the Behavioral Health Service Providers assign a case manager prior to or on the date of discharge and provide case management services to Members with severe mental illness and co-occurring developmental disabilities who are discharged from a state operated or state contracted psychiatric facility or state operated nursing facility for Members with severe mental illness.				
The Case Manager and other identified behavioral health service providers shall participate in discharge planning meetings to ensure compliance with federal Olmstead and other applicable laws. Appropriate discharge planning shall be focused on ensuring needed supports and services are available in the least restrictive environment to meet the Member's behavioral and physical health needs, including psychosocial rehabilitation and health promotion.				
Appropriate follow up by the Behavioral Health Service provider shall occur to ensure the community supports are meeting the needs of the Member discharged from a state operated or state contracted psychiatric hospital.				
The Contractor shall ensure the Behavioral				

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Health Service Providers assist Members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.				
33.11 Program and Standards				
Appropriate information sharing and careful monitoring of diagnosis, treatment, and follow-up and medication usage are especially important when Members use physical and behavioral health systems simultaneously. The Contractor shall:				
A. Establish guidelines and procedures to ensure accessibility, availability, referral and triage to effective physical and behavioral health care, including emergency behavioral health services, (i.e. Suicide Prevention and community crisis stabilization);				
B. Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;	**Minimal** - Documents provided discuss coordination of care and sharing of information. MHNet Provider Quick Reference Guide references coordination of medication usage. Documents for non-behavioral health providers, such as the Provider Manual and physician contract do not specifically address sharing of medication usage information. **MCO Response:** MHNet has a process in place to address polypharmacy issues through the pharmacy department.	Full	Addressed in Pharmacy Anti-Fraud, Waste and Abuse Guide (page 2) and MHNet Provider Quick Reference Guide (page 15). The Reference Guide makes note of the need to share information with the PCP, especially when the member is on medication. CCKY/MHNet also provided copies of provider newsletters prepared for PCPs (8/2013) and BH practitioners and facilities (5/2013)	

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	MHNet facilitates coordination of information between PCPs and Behavioral health Providers. Please see enclosed documentation. MHNet facilitates communication between Primary Care Physicians and Behavioral Health Providers. Members are requested to give permission for MHNet to provide copies of their outpatient treatment plan request (OTR) to their primary care physician. The OTR is submitted by the behavioral health provider to request additional authorization for treatment. It includes current diagnosis, clinical information, risk factors and medications. This treatment plan is usually received and forwarded by MHNet every three to six months. Behavioral health providers and primary care physicians are encouraged to communicate in addition to this program to ensure members' needs are met. Members receive the consent form to allow MHNet to send clinical information to their PCP at the time they first access services in the member brochure. There continues to be the barrier that members may be hesitant to share behavioral health information with their PCP. MHNet in partnership with the health plans will educate members and providers about the		which addressed coordination of care, including BH medications. During the interview, CCKY/MHNet described the process used to address polypharmacy issues. This is accomplished through the pharmacy department's Drug Utilization Review (DUR) program. CCKY/MHNet provided documentation, including the list of drug edits by class and specific drug name(s) which are monitored via hard edits. CCKY/MHNet also coordinates sharing the Outpatient Treatment Plan with the PCP with member consent. CCKY/MHNet indicated that there are barriers due to members' not consenting. The Provider Quick Reference Guide encourages BH providers to educate members regarding the importance of sharing information and the potential dangers of not sharing information.	

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	importance and positive outcomes of coordinated care. MHNet routinely completes treatment record review to ensure that quality care is being provided to members and documented. As part of this process MHNet monitors to ensure that behavioral health and primary care providers are communicating to provide coordinated services to the member.			
C. Identify a method to evaluate the continuity and coordination of care, including member-approved communications between behavioral health care providers and primary care providers;				
D. Protect the confidentiality of Member information and records; and				
E. Monitor and evaluate the above, which shall be a part of the Quality Improvement Plan.				
The Department and DBHDID shall monitor referral patterns between physical and behavioral providers to evaluate coordination and continuity of care. Drug utilization patterns of psychopharmacological medications shall be closely monitored. The findings of these evaluations will be provided to the Contractor.				

Behavioral Health Services

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	4	4	0	0
Total Points	12	8	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.5**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Behavioral Health Services
Suggested Evidence

Documents

Policies/procedures for:

- Behavioral Health services
- Clinical coordination between BH services providers and PCPs
- BH provider program capacity requirements
- BH services hotline
- Court-ordered services
- Case management services for members including discharge planning
- Accessing free or discounted medication

Benefit Summary (covered/non-covered BH services)
Provider Manual
Sample PCP contract
Sample BH provider contract
Process for educating members of where and how to obtain BH services
Process for monitoring compliance with hotline requirements
Process for educating PCPs of BH services/requirements
Evidence of training of PCPs regarding BH services/requirements
Sample participation agreement with CMHCs
Sample collaborative agreement with state operated or state contracted psychiatric hospitals
Process for coordination of services for members committed by court of law to the state psychiatric hospital
Guidelines/procedures ensuring accessibility, availability, referral and triage including emergency BH services
Process for facilitating the exchange of pharmaceutical information among providers
Process for evaluating continuity and coordination of care among providers
QI Plan

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Process for monitoring BH providers participation in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.

Reports

Reports of access and availability of BH providers
Provider program capacity/program mapping reports
Evidence of monitoring of compliance with hotline requirements
Evidence of ensuring follow-up after hospitalization for BH services
Evidence of monitoring compliance with BH standards

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Appendix U

Appendix U

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2.14 (Q1) Implementation Plan

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Implementation Plan

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Appendix V

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14 (Q4) Medicaid HEDIS Scores

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2014 Audited Medicaid HEDIS Rate Summary

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2014 Audited HEDIS Rate Summary

Measure/Data Element	HEDIS 2014 50th Percentile	HEDIS 2014 75th Percentile	Aetna Better Health Inc., an Illinois Corporation (Org ID: 15355, SubID: 11017, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Aetna Better Health of Texas (Org ID: 19734, SubID: 11018, Medicaid, Spec Area: Bexar, Spec Proj: TX Medicaid); Measurement Year - 2013	Aetna Better Health of Texas (Org ID: 19734, SubID: 11020, Medicaid, Spec Area: Tarrant, Spec Proj: TX Medicaid); Measurement Year - 2013	Aetna Better Health Inc., a Pennsylvania Corporation (Org ID: 14391, SubID: 10506, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Carilion Clinic Medicare Resources, LLC d/b/a MajestaCare Healthplan (Org ID: 16305, SubID: 11093, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	CHRISTUS Health Plan (Org ID: 21351, SubID: 11287, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	CoventryCares of Michigan (Org ID: 203, SubID: 4055, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Coventry Health Care of Florida, Inc. (Org ID: 300, SubID: 6650, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Coventry Health Care of Nebraska, Inc. (Org ID: 1797, SubID: 10501, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Coventry Health Care of Virginia, Inc. (Org ID: 315, SubID: 4368, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Coventry Health Care of West Virginia, Inc. (Org ID: 194, SubID: 4403, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Coventry Health & Life Insurance Company dba CoventryCares of Kentucky (Org ID: 19497, SubID: 10962, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Coventry Health Plan of Florida, Inc. (Org ID: 255, SubID: 4066, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Delaware Physicians Care, Incorporated (Org ID: 4534, SubID: 7136, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	HealthAmerica Pennsylvania, Inc. (Org ID: 1111, SubID: 10442, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	HealthCare USA of Missouri, LLC (Org ID: 1623, SubID: 11139, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Maryland Care Inc., d/b/a/ Maryland Physicians Care (Org ID: 1638, SubID: 6062, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Parkland Community Health Plan (Org ID: 19735, SubID: 11065, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Average of Aetna Medicaid Scores	Does Average Score Exceed 2013 NCQA HMO National 50th Percentile for Medicaid Product Lines?	Does Average Score Exceed 2013 NCQA HMO National 75th Percentile for Medicaid Product Lines?
Effectiveness of Care: Prevention and Screening																							
Adult BMI Assessment (aba)	**78.81%**	**85.23%**	70.58%	NR	NR	74.77%	79.69%	NR	84.62%	75.18%	83.74%	82.89%	71.54%	60.88%	88.40%	83.22%	81.58%	78.86%	70.16%	NR	77.58%	N	N
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)																							
BMI Percentile	**57.40%**	**73.72%**	NR	NR	NR	62.73%	44.59%	NR	71.53%	43.07%	33.80%	49.42%	53.77%	25.00%	73.38%	76.82%	55.56%	36.57%	46.53%	NR	51.75%	N	N
Counseling for Nutrition	**60.58%**	**69.21%**	NR	NR	NR	67.36%	44.15%	NR	62.50%	63.75%	43.98%	59.86%	52.55%	23.84%	70.37%	72.85%	70.37%	43.75%	54.40%	NR	56.13%	N	N
Counseling for Physical Activity	**51.16%**	**60.82%**	NR	NR	NR	51.16%	33.33%	NR	48.15%	50.85%	42.82%	51.04%	35.77%	21.99%	65.97%	69.76%	62.50%	38.66%	58.80%	NR	48.52%	N	N
Childhood Immunization Status (cis)																							
DTaP	**80.05%**	**84.07%**	NR	77.55%	81.25%	79.40%	77.35%	71.20%	75.23%	66.18%	78.47%	76.16%	76.64%	78.19%	78.47%	88.58%	78.70%	76.16%	77.91%	87.50%	77.94%	N	N
IPV	**91.24%**	**93.92%**	NR	87.73%	91.67%	89.58%	89.55%	88.00%	90.51%	77.62%	89.35%	91.67%	93.92%	91.18%	87.04%	97.04%	90.74%	93.29%	91.40%	94.21%	90.26%	N	N
MMR	**91.00%**	**93.29%**	NR	91.67%	92.59%	88.43%	89.20%	90.40%	92.59%	89.29%	90.74%	89.58%	87.83%	90.28%	92.13%	93.87%	89.58%	89.58%	93.02%	96.76%	91.03%	Y	N
HiB	**91.48%**	**94.04%**	NR	89.81%	92.82%	88.89%	90.59%	88.00%	88.89%	88.81%	87.04%	94.21%	94.16%	93.04%	93.98%	97.25%	90.28%	92.36%	92.33%	96.06%	91.68%	Y	N
Hepatitis B	**90.73%**	**93.43%**	NR	89.58%	90.28%	87.96%	83.62%	86.40%	94.91%	76.64%	86.81%	87.96%	93.92%	87.70%	81.94%	94.50%	90.51%	92.36%	93.26%	93.29%	88.92%	N	N
VZV	**91.20%**	**93.16%**	NR	91.44%	92.36%	89.12%	90.94%	90.40%	91.67%	88.81%	91.20%	91.20%	87.59%	92.11%	93.98%	93.87%	90.51%	88.89%	92.09%	96.30%	91.32%	Y	N
Pneumococcal Conjugate	**80.56%**	**84.95%**	NR	76.16%	85.65%	79.17%	79.44%	68.80%	71.76%	72.75%	81.94%	76.85%	75.91%	79.12%	78.94%	88.79%	79.86%	76.62%	85.81%	87.73%	79.14%	N	N
Hepatitis A	**82.68%**	**88.54%**	NR	89.81%	91.44%	82.18%	83.28%	88.80%	84.72%	73.72%	81.94%	81.02%	85.16%	72.39%	82.18%	90.06%	81.71%	76.39%	76.51%	94.21%	83.27%	Y	N
Rotavirus	**69.21%**	**74.31%**	NR	66.90%	70.60%	73.84%	68.29%	56.80%	60.42%	58.88%	72.92%	68.06%	67.15%	60.79%	65.05%	80.76%	62.27%	69.21%	59.07%	72.69%	66.69%	N	N
Influenza	**50.79%**	**58.88%**	NR	38.19%	40.28%	62.04%	48.08%	26.40%	30.79%	31.39%	55.32%	53.70%	45.74%	35.50%	22.69%	70.19%	54.17%	49.07%	46.28%	50.46%	44.72%	N	N
Combination #2	**75.18%**	**79.72%**	NR	74.54%	76.62%	71.53%	70.73%	65.60%	73.61%	60.34%	71.76%	71.06%	72.02%	71.69%	69.68%	83.93%	75.46%	72.22%	73.72%	83.10%	72.80%	N	N
Combination #3	**72.33%**	**77.78%**	NR	70.37%	75.46%	67.36%	67.94%	57.60%	68.29%	54.99%	69.91%	64.58%	67.40%	67.52%	63.66%	82.03%	72.69%	66.67%	72.09%	79.86%	68.73%	N	N
Combination #4	**65.94%**	**72.51%**	NR	68.98%	74.07%	62.96%	63.07%	57.60%	65.05%	49.39%	65.28%	59.03%	64.96%	54.52%	58.56%	79.07%	67.36%	60.42%	62.79%	78.01%	64.18%	N	N
Combination #5	**57.87%**	**64.48%**	NR	58.10%	60.19%	58.80%	53.66%	44.80%	53.01%	43.07%	60.88%	51.85%	52.80%	48.96%	48.61%	70.61%	53.70%	53.24%	46.98%	65.28%	54.38%	N	N
Combination #6	**42.82%**	**50.69%**	NR	32.41%	34.95%	50.69%	39.37%	20.80%	27.78%	21.65%	46.30%	41.67%	36.74%	26.91%	19.21%	61.95%	46.30%	39.58%	37.67%	45.37%	37.02%	N	N
Combination #7	**54.63%**	**61.42%**	NR	57.18%	59.03%	55.79%	50.52%	44.80%	51.16%	39.42%	57.64%	48.61%	51.34%	42.23%	46.06%	68.92%	50.23%	48.15%	43.95%	64.58%	51.74%	N	N
Combination #8	**40.15%**	**47.73%**	NR	31.71%	34.72%	49.31%	37.63%	20.80%	27.31%	20.92%	44.91%	39.12%	36.01%	23.90%	18.06%	60.68%	44.44%	36.57%	34.88%	44.91%	35.64%	N	N
Combination #9	**36.34%**	**43.93%**	NR	28.47%	30.09%	46.53%	33.10%	16.80%	23.61%	18.49%	42.13%	36.11%	30.41%	22.04%	16.20%	54.76%	35.19%	33.80%	28.37%	38.43%	31.44%	N	N
Combination #10	**34.18%**	**41.85%**	NR	28.01%	29.86%	45.60%	31.71%	16.80%	23.38%	18.25%	40.97%	34.03%	29.93%	20.19%	15.28%	54.12%	34.03%	31.02%	27.67%	38.19%	30.53%	N	N
Immunizations for Adolescents (ima)																							
Meningococcal	**73.38%**	**82.39%**	NR	66.40%	78.97%	78.94%	NR	74.42%	86.45%	54.01%	71.89%	55.56%	85.53%	76.62%	74.07%	76.92%	76.32%	57.41%	65.74%	83.36%	72.66%	N	N
Tdap/Td	**86.23%**	**90.39%**	NR	69.84%	76.91%	80.32%	NR	72.87%	87.18%	76.64%	84.32%	92.59%	86.84%	86.11%	85.88%	79.49%	76.83%	63.89%	70.60%	83.51%	79.61%	N	N
Combination #1	**71.29%**	**80.90%**	NR	64.78%	75.26%	77.08%	NR	72.87%	84.98%	51.82%	70.71%	53.94%	83.42%	75.23%	70.83%	74.62%	74.56%	55.09%	62.73%	81.03%	70.56%	N	N
Human Papillomavirus Vaccine for Female Adolescents (hpv)	**19.21%**	**23.62%**	NR	NR	NR	19.23%	NR	NR	14.35%	10.67%	19.91%	17.72%	23.60%	16.32%	22.47%	30.68%	17.74%	15.05%	NR	NR	18.89%	N	N
Lead Screening in Children (lsc)	**70.86%**	**80.83%**	NR	16.55%	39.90%	67.59%	65.16%	37.60%	82.41%	36.74%	65.51%	67.59%	59.37%	66.13%	70.14%	69.77%	71.30%	68.98%	NR	39.84%	57.79%	N	N
Breast Cancer Screening (bcs)	**57.37%**	**65.12%**	46.09%	NA	NA	47.92%	NA	NR	66.81%	56.21%	57.47%	60.73%	50.00%	NA	55.51%	57.86%	56.35%	46.85%	48.46%	NA	54.19%	N	N
Cervical Cancer Screening (ccs)	**NA**	**NA**	43.85%	NR	NR	53.95%	46.17%	NR	70.92%	59.61%	54.75%	66.02%	55.23%	51.41%	62.18%	67.95%	58.51%	65.52%	79.58%	NR	59.69%	NA	NA
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	**NA**	**NA**	NR	NR	NR	2.71%	NR	NR	10.28%	7.68%	6.33%	5.22%	7.85%	9.62%	8.20%	6.09%	5.17%	4.30%	NR	NR	6.68%	N	N
Chlamydia Screening in Women (chl)																							
16-20 Years	**51.61%**	**58.68%**	NA	52.69%	51.80%	54.60%	31.75%	53.97%	68.26%	53.35%	30.61%	46.49%	39.23%	44.13%	64.10%	62.50%	57.17%	53.31%	58.15%	41.97%	50.83%	N	N
21-24 Years	**63.32%**	**69.23%**	44.02%	61.90%	64.36%	59.43%	42.42%	NA	77.30%	73.24%	39.15%	64.71%	53.22%	58.71%	67.94%	72.61%	65.84%	69.10%	67.06%	63.27%	61.43%	N	N
Total	**54.93%**	**62.75%**	45.93%	54.49%	54.93%	56.57%	35.86%	63.22%	70.99%	62.40%	33.19%	53.64%	43.89%	48.27%	65.15%	67.19%	61.09%	57.66%	62.00%	44.75%	54.51%	N	N
Effectiveness of Care: Respiratory Conditions																							
Appropriate Testing for Children with Pharyngitis (cwp)	**68.53%**	**77.96%**	NR	49.49%	66.14%	67.71%	67.00%	50.00%	50.62%	63.94%	NR	77.41%	NB	62.72%	77.96%	60.40%	70.94%	77.99%	78.42%	74.63%	66.36%	N	N
Appropriate Treatment for Children With URI (uri)	**86.11%**	**91.21%**	NR	87.96%	81.17%	88.43%	75.09%	75.39%	88.45%	84.48%	NR	79.42%	NB	58.33%	88.26%	86.59%	83.25%	82.58%	86.62%	84.27%	82.02%	N	N
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	**24.31%**	**30.54%**	18.98%	NR	NR	31.96%	12.24%	NR	30.77%	36.63%	NR	18.35%	NB	16.60%	7.41%	20.62%	35.59%	24.25%	22.01%	NR	22.95%	N	N
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	**30.08%**	**36.73%**	NA	NA	NA	NA	NA	NR	45.49%	15.38%	27.27%	40.43%	NA	NA	NA	32.45%	NA	25.58%	21.05%	NA	29.66%	N	N
Pharmacotherapy Management of COPD Exacerbation (pce)																							
Systemic Corticosteroid	**68.91%**	**74.94%**	69.21%	NA	NA	70.00%	78.08%	NR	78.82%	72.09%	NR	75.00%	NB	65.10%	NA	74.82%	68.61%	61.11%	72.61%	NA	71.40%	Y	N
Bronchodilator	**83.82%**	**87.61%**	89.40%	NA	NA	76.67%	79.45%	NR	92.94%	81.40%	NR	89.42%	NB	80.66%	NA	83.21%	80.91%	86.11%	84.93%	NA	84.10%	Y	N
Use of Appropriate Medications for People With Asthma (asm)																							
5-11 Years	**91.11%**	**93.59%**	NA	96.92%	91.82%	91.95%	NA	NA	84.31%	80.00%	NR	90.58%	NB	94.38%	83.33%	92.72%	85.71%	91.12%	91.36%	94.59%	89.91%	N	N
12-18 Years	**87.31%**	**89.52%**	NA	92.31%	93.75%	93.40%	NA	NA	83.66%	77.42%	NR	83.33%	NB	88.38%	NA	90.49%	NA	87.66%	90.42%	94.60%	88.67%	Y	N
19-50 Years	**75.83%**	**80.12%**	76.04%	NA	NA	78.81%	NA	NA	68.32%	69.70%	NR	66.67%	NB	57.89%	NA	76.18%	71.79%	69.23%	80.09%	NA	71.47%	N	N
51-64 Years	**71.63%**	**77.21%**	75.84%	NA	NA	85.37%	NA	NA	64.29%	NA	NR	NA	NB	50.00%	NA	84.44%	NA	NA	76.26%	NA	72.70%	Y	N
Total	**84.96%**	**87.26%**	75.95%	94.55%	92.07%	87.50%	80.88%	NA	77.02%	76.97%	NR	82.97%	NB	84.31%	72.73%	87.31%	78.22%	88.75%	86.97%	94.48%	84.05%	N	N
Medication Management for People With Asthma (mma)																							
5-11 Years - Medication Compliance 50%	**0.00%**	**0.00%**	NA	65.08%	52.48%	49.38%	NA	NA	37.66%	40.85%	NR	54.80%	NB	67.98%	50.00%	55.41%	43.33%	54.10%	56.84%	44.89%	51.75%	Y	Y
5-11 Years - Medication Compliance 75%	**26.63%**	**32.32%**	NA	29.37%	22.77%	33.75%	NA	NA	13.85%	28.17%	NR	26.80%	NB	42.92%	20.00%	29.19%	33.33%	29.60%	31.18%	18.46%	27.65%	Y	N
12-18 Years - Medication Compliance 50%	**0.00%**	**0.00%**	NA	36.67%	48.89%	55.56%	NA	NA	43.26%	NA	NR	46.67%	NB	65.91%	NA	51.64%	NA	53.25%	54.87%	39.93%	49.67%	Y	Y
12-18 Years - Medication Compliance 75%	**24.62%**	**30.58%**	NA	25.00%	20.00%	33.33%	NA	NA	20.47%	NA	NR	27.41%	NB	43.28%	NA	26.40%	NA	28.68%	30.60%	16.04%	27.12%	Y	N
19-50 Years - Medication Compliance 50%	**0.00%**	**0.00%**	85.62%	NA	NA	60.50%	NA	NA	57.97%	NA	NR	64.29%	NB	66.77%	NA	59.15%	NA	59.48%	59.80%	NA	64.20%	Y	Y
19-50 Years - Medication Compliance 75%	**36.00%**	**40.36%**	69.18%	NA	NA	40.34%	NA	NA	36.71%	NA	NR	46.43%	NB	46.11%	NA	38.03%	NA	28.10%	34.65%	NA	42.44%	Y	Y
51-64 Years - Medication Compliance 50%	**0.00%**	**0.00%**	86.73%	NA	NA	77.14%	NA	NA	74.07%	NA	NR	NA	NB	86.17%	NA	72.37%	NA	NA	73.58%	NA	78.34%	Y	Y
51-64 Years - Medication Compliance 75%	**50.99%**	**56.67%**	75.22%	NA	NA	57.14%	NA	NA	57.41%	NA	NR	NA	NB	63.83%	NA	50.00%	NA	NA	51.89%	NA	59.25%	Y	Y
Total - Medication Compliance 50%	**0.00%**	**0.00%**	86.10%	56.54%	51.66%	56.42%	67.27%	NA	48.09%	49.21%	NR	54.08%	NB	67.72%	47.50%	56.06%	60.26%	53.98%	57.92%	43.59%	57.09%	Y	Y
Total - Medication Compliance 75%	**30.16%**	**34.96%**	71.81%	28.80%	21.85%	37.53%	45.45%	NA	25.88%	27.78%	NR	29.58%	NB	44.04%	18.75%	31.49%	39.74%	29.21%	32.91%	17.77%	33.51%	Y	N
Asthma Medication Ratio (amr)																							
5-11 Years	**78.28%**	**82.16%**	NA	84.62%	87.62%	76.74%	NA	NA	70.54%	71.08%	NR	81.48%	NB	85.71%	75.44%	80.08%	65.71%	71.20%	79.55%	84.44%	78.02%	N	N
12-18 Years	**67.15%**	**70.95%**	NA	75.00%	70.83%	73.58%	NA	NA	59.92%	NA	NR	68.13%	NB	71.74%	NA	74.95%	NA	64.80%	72.12%	78.31%	70.94%	Y	N
19-50 Years	**49.29%**	**55.36%**	58.73%	NA	NA	62.16%	NA	NA	40.68%	60.61%	NR	51.22%	NB	38.81%	NA	58.98%	47.37%	45.62%	54.72%	NA	51.89%	Y	N
51-64 Years	**52.26%**	**58.93%**	59.73%	NA	NA	70.73%	NA	NA	33.33%	NA	NR	NA	NB	38.83%	NA	77.78%	NA	NA	55.40%	NA	55.97%	Y	N
Total	**66.38%**	**70.88%**	59.17%	81.50%	82.39%	70.88%	64.71%	NA	54.11%	66.45%	NR	70.52%	NB	71.31%	59.43%	73.08%	58.00%	67.51%	69.08%	82.55%	68.71%	Y	N

2014 Audited HEDIS Rate Summary

Measure/Data Element	HEDIS 2014 50th Percentile	HEDIS 2014 75th Percentile	Aetna Better Health Inc., an Illinois Corporation (Org ID: 15355, SubID: 11017, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Aetna Better Health of Texas (Org ID: 19734, SubID: 11018, Medicaid, Spec Area: Bexar, Spec Proj: TX Medicaid); Measurement Year - 2013	Aetna Better Health of Texas (Org ID: 19734, SubID: 11020, Medicaid, Spec Area: Tarrant, Spec Proj: TX Medicaid); Measurement Year - 2013	Aetna Better Health Inc., a Pennsylvania Corporation (Org ID: 14391, SubID: 10506, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Carilion Clinic Medicare Resources, LLC d/b/a MajestaCare Healthplan (Org ID: 16305, SubID: 11093, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	CHRISTUS Health Plan (Org ID: 21351, SubID: 11287, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	CoventryCares of Michigan (Org ID: 203, SubID: 4055, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Coventry Health Care of Florida, Inc. (Org ID: 300, SubID: 6650, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Coventry Health Care of Nebraska, Inc. (Org ID: 1797, SubID: 10501, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Coventry Health Care of Virginia, Inc. (Org ID: 315, SubID: 4368, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Coventry Health Care of West Virginia, Inc. (Org ID: 194, SubID: 4403, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Coventry Health & Life Insurance Company dba CoventryCares of Kentucky (Org ID: 19497, SubID: 10962, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Coventry Health Plan of Florida, Inc. (Org ID: 255, SubID: 4066, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Delaware Physicians Care, Incorporated (Org ID: 4534, SubID: 7136, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	HealthAmerica Pennsylvania, Inc. (Org ID: 1111, SubID: 10442, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	HealthCare USA of Missouri, LLC (Org ID: 1623, SubID: 11139, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Maryland Care Inc., d/b/a/ Maryland Physicians Care (Org ID: 1638, SubID: 6062, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Parkland Community Health Plan (Org ID: 19735, SubID: 11065, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Average of Aetna Medicaid Scores	Does Average Score Exceed 2013 NCQA HMO National 50th Percentile for Medicaid Product Lines?	Does Average Score Exceed 2013 NCQA HMO National 75th Percentile for Medicaid Product Lines?
Effectiveness of Care: Cardiovascular																							
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)																							
LDL-C Screening Performed	**81.46%**	**84.91%**	81.46%	NA	NA	77.78%	NA	NA	83.76%	85.96%	81.11%	84.55%	NA	79.63%	94.59%	79.47%	67.39%	NA	77.26%	NA	81.18%	N	N
LDL-C Control (<100 mg/dL)	**41.43%**	**47.64%**	28.04%	NA	NA	42.86%	NA	NA	45.69%	43.86%	48.89%	39.09%	NA	29.63%	47.30%	46.36%	43.48%	NA	34.11%	NA	40.85%	N	N
Controlling High Blood Pressure (cbp)	**56.46%**	**63.76%**	53.30%	NR	NR	55.43%	58.41%	NR	50.00%	43.07%	59.53%	57.18%	56.02%	54.22%	60.56%	65.21%	62.24%	47.23%	46.78%	NR	54.94%	N	N
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	**86.36%**	**91.18%**	93.33%	NA	NA	NA	NA	NA	NA	NA	NR	NA	NB	89.87%	NA	85.71%	NA	NA	87.50%	NA	89.10%	Y	N
Effectiveness of Care: Diabetes																							
Comprehensive Diabetes Care (cdc)																							
Hemoglobin A1c (HbA1c) Testing	**83.88%**	**87.59%**	85.62%	NR	NR	79.36%	88.05%	NR	84.33%	81.27%	87.94%	82.87%	72.86%	83.08%	84.47%	80.64%	84.36%	72.03%	79.47%	NR	81.88%	N	N
HbA1c Poor Control (>9.0%)	**44.69%**	**36.52%**	60.84%	NR	NR	46.64%	39.48%	NR	38.47%	43.07%	36.54%	43.98%	48.66%	45.73%	35.69%	38.56%	37.91%	60.61%	48.57%	NR	44.63%	N	Y
HbA1c Control (<8.0%)	**46.43%**	**52.89%**	33.85%	NR	NR	45.47%	52.47%	NR	52.59%	48.42%	52.45%	47.69%	41.32%	45.43%	55.04%	51.52%	51.82%	32.40%	43.27%	NR	46.70%	Y	N
HbA1c Control (<7.0%)	**36.27%**	**40.26%**	NR	NR	NR	31.52%	37.86%	NR	39.78%	NR	36.63%	NR	29.84%	36.38%	NR	36.63%	39.73%	NR	NR	NR	36.05%	N	N
Eye Exam (Retinal) Performed	**54.14%**	**63.14%**	45.58%	NR	NR	48.15%	41.30%	NR	62.82%	44.77%	60.84%	49.54%	32.27%	38.11%	54.22%	61.44%	56.56%	48.95%	71.96%	NR	51.18%	N	N
LDL-C Screening Performed	**76.88%**	**80.18%**	83.63%	NR	NR	73.83%	78.18%	NR	79.40%	79.56%	70.10%	74.31%	60.64%	78.66%	86.38%	73.92%	79.46%	62.24%	72.85%	NR	75.23%	N	N
LDL-C Control (<100 mg/dL)	**34.00%**	**40.44%**	25.44%	NR	NR	30.54%	30.91%	NR	40.80%	33.58%	36.19%	33.10%	22.00%	28.81%	34.06%	35.36%	38.70%	24.01%	30.46%	NR	31.71%	N	N
Medical Attention for Nephropathy	**80.05%**	**83.11%**	80.53%	NR	NR	81.04%	75.06%	NR	82.90%	75.67%	78.67%	79.40%	55.26%	79.57%	83.11%	80.80%	81.36%	61.77%	75.28%	NR	76.46%	N	N
Blood Pressure Control (< 140/80 mm Hg)	**39.42%**	**45.50%**	27.43%	NR	NR	37.25%	39.48%	NR	31.61%	30.41%	46.85%	35.65%	36.67%	32.16%	31.61%	45.44%	45.97%	32.87%	32.01%	NR	36.10%	N	N
Blood Pressure Control (< 140/90 mm Hg)	**61.31%**	**70.07%**	40.93%	NR	NR	58.89%	62.08%	NR	50.13%	50.85%	71.50%	59.95%	64.30%	52.13%	61.31%	72.16%	71.25%	56.64%	55.41%	NR	59.11%	N	N
Effectiveness of Care: Musculoskeletal																							
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	**70.71%**	**77.17%**	NR	NR	NR	74.36%	NA	NR	74.63%	NA	NR	64.29%	NB	65.84%	NA	77.20%	62.71%	67.74%	73.83%	NR	70.08%	N	N
Use of Imaging Studies for Low Back Pain (lbp)	**75.25%**	**78.53%**	73.25%	NA	82.35%	75.34%	65.42%	NA	80.26%	77.02%	76.21%	68.60%	65.50%	69.18%	58.49%	74.54%	74.40%	70.48%	76.58%	74.49%	72.63%	N	N
Effectiveness of Care: Behavioral Health																							
Antidepressant Medication Management (amm)																							
Effective Acute Phase Treatment	**49.66%**	**54.31%**	76.99%	65.22%	61.11%	52.98%	46.32%	NR	44.26%	43.97%	NR	50.12%	NB	59.33%	54.31%	48.91%	50.95%	54.93%	NA	50.00%	54.24%	Y	N
Effective Continuation Phase Treatment	**33.93%**	**38.23%**	64.52%	45.65%	36.11%	39.22%	36.76%	NR	28.20%	30.50%	NR	34.87%	NB	42.59%	36.21%	31.56%	33.23%	38.09%	NA	34.21%	37.98%	Y	N
Follow-Up Care for Children Prescribed ADHD Medication (add)																							
Initiation Phase	**41.09%**	**46.99%**	NR	34.25%	38.84%	15.30%	43.33%	21.28%	25.25%	46.99%	NR	26.59%	NB	49.85%	56.19%	34.82%	20.78%	28.15%	19.12%	25.32%	32.40%	N	N
Continuation and Maintenance (C&M) Phase	**49.51%**	**57.55%**	NR	NA	NA	10.59%	NA	NA	27.91%	NA	NR	40.58%	NB	52.68%	NA	46.07%	NA	30.36%	20.95%	27.81%	32.12%	N	N
Follow-Up After Hospitalization for Mental Illness (fuh)																							
30-Day Follow-Up	**64.63%**	**74.09%**	49.59%	38.67%	55.48%	NB	47.00%	9.68%	NB	26.87%	NR	66.32%	NB	63.37%	51.85%	57.24%	NB	69.53%	NB	NB	48.69%	N	N
7-Day Follow-Up	**42.30%**	**54.45%**	26.19%	26.67%	38.06%	NB	24.00%	3.23%	NB	15.30%	NR	42.93%	NB	38.98%	37.65%	36.78%	NB	46.36%	NB	NB	30.56%	N	N
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	**79.38%**	**82.88%**	NR	NA	NA	81.97%	85.57%	NA	NB	76.60%	NR	77.62%	NB	75.32%	82.14%	72.94%	86.18%	78.44%	NR	NA	79.64%	Y	N
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	**70.05%**	**73.76%**	NR	NA	NA	NA	NA	NA	NR	NA	58.97%	70.00%	NA	71.21%	NA	70.09%	65.71%	NA	NR	NA	67.20%	N	N
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	**81.20%**	**84.21%**	NR	NA	NA	NA	NA	NA	NR	NA	NA	NA	NA	NA	NA	NA	NA	NA	NR	NA	NA	NA	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	**61.37%**	**67.13%**	81.29%	NA	NA	60.24%	76.79%	NA	NB	50.56%	NR	61.07%	NB	61.79%	58.33%	59.08%	54.00%	45.21%	NR	NA	60.84%	N	N
Effectiveness of Care: Medication Management																							
Annual Monitoring for Patients on Persistent Medications (mpm)																							
ACE Inhibitors or ARBs	**88.00%**	**89.94%**	89.89%	NA	88.52%	89.11%	93.16%	NA	84.57%	89.23%	NR	90.75%	NB	88.97%	92.45%	85.20%	85.49%	85.99%	86.99%	84.78%	88.22%	Y	N
Digoxin	**91.91%**	**94.12%**	86.81%	NA	NA	NA	NA	NA	84.62%	NA	NR	NA	NB	90.24%	NA	90.74%	90.91%	NA	92.19%	NA	89.25%	N	N
Diuretics	**87.90%**	**90.57%**	89.97%	NA	81.63%	86.48%	92.91%	NA	83.50%	91.25%	NR	91.62%	NB	89.80%	95.16%	84.68%	87.21%	85.69%	86.23%	88.33%	88.18%	Y	N
Anticonvulsants	**66.47%**	**69.53%**	81.21%	NA	NA	66.20%	70.09%	NA	58.50%	70.59%	NR	66.36%	NB	64.23%	68.18%	59.28%	66.38%	67.22%	70.42%	NA	67.39%	Y	N
Total	**86.14%**	**88.25%**	88.24%	80.49%	84.75%	85.49%	90.38%	NA	81.43%	88.47%	NR	88.46%	NB	87.07%	92.31%	83.13%	83.74%	83.55%	86.27%	85.00%	85.92%	N	N
Access/Availability of Care																							
Adults' Access to Preventive/Ambulatory Health Services (aap)																							
20-44 Years	**83.27%**	**86.21%**	74.19%	85.37%	81.69%	71.71%	85.05%	69.95%	80.06%	69.34%	88.05%	83.79%	84.19%	86.43%	69.58%	85.63%	75.81%	81.37%	81.10%	79.33%	79.59%	N	N
45-64 Years	**88.74%**	**90.98%**	88.12%	81.40%	88.70%	81.66%	93.79%	NA	87.53%	81.27%	91.61%	91.98%	83.60%	92.16%	80.91%	90.35%	85.90%	81.46%	87.77%	83.21%	86.55%	N	N
65+ Years	**88.28%**	**90.70%**	74.39%	NA	NA	83.51%	93.48%	NA	NA	66.29%	91.82%	89.81%	NA	86.47%	69.81%	90.36%	82.17%	NA	NA	NA	82.81%	N	N
Total	**84.89%**	**88.11%**	80.39%	85.00%	82.66%	74.87%	88.78%	70.94%	82.82%	71.97%	89.26%	86.67%	84.14%	88.62%	72.71%	87.18%	79.30%	81.38%	82.77%	79.74%	81.62%	N	N
Children and Adolescents' Access to Primary Care Practitioners (cap)																							
12-24 Months	**96.96%**	**97.86%**	NR	97.14%	96.01%	95.01%	98.68%	96.88%	94.60%	93.86%	97.45%	97.96%	97.74%	95.46%	97.24%	97.55%	94.55%	96.78%	96.54%	97.86%	96.55%	N	N
25 Months - 6 Years	**89.08%**	**91.73%**	NR	89.65%	85.23%	82.16%	92.94%	87.40%	82.98%	84.97%	90.11%	91.36%	92.54%	92.42%	93.94%	91.32%	85.96%	87.32%	89.99%	91.73%	88.94%	N	N
7-11 Years	**91.15%**	**93.50%**	NR	89.42%	87.66%	81.67%	93.01%	NA	88.05%	82.91%	90.07%	90.71%	94.41%	97.57%	91.24%	94.21%	79.52%	88.85%	92.06%	93.75%	89.69%	N	N
12-19 Years	**89.94%**	**92.17%**	NR	89.57%	83.17%	78.08%	90.46%	NA	85.79%	82.10%	93.26%	88.23%	93.48%	96.39%	88.29%	91.13%	75.72%	88.53%	88.51%	92.29%	87.81%	N	N
Annual Dental Visit (adv)																							
2-3 Years	**37.51%**	**43.98%**	NA	NB	NB	40.15%	NB	NB	NB	NR	NR	NB	NB	37.77%	NR	NB	29.34%	27.83%	NR	NB	33.77%	N	N
4-6 Years	**59.99%**	**68.85%**	NA	NB	NB	59.14%	NB	NB	NB	NR	NR	NB	NB	68.16%	NR	NB	51.24%	55.33%	NR	NB	58.47%	N	N
7-10 Years	**60.95%**	**71.57%**	NA	NB	NB	57.61%	NB	NB	NB	NR	NR	NB	NB	67.10%	NR	NB	50.91%	60.55%	NR	NB	59.04%	N	N
11-14 Years	**57.78%**	**65.61%**	NA	NB	NB	52.28%	NB	NB	NB	NR	NR	NB	NB	61.13%	NR	NB	47.69%	52.75%	NR	NB	53.46%	N	N
15-18 Years	**51.48%**	**56.52%**	NA	NB	NB	43.51%	NB	NB	NB	NR	NR	NB	NB	53.24%	NR	NB	41.71%	46.25%	NR	NB	46.18%	N	N

2014 Audited HEDIS Rate Summary

Measure/Data Element	HEDIS 2014 50th Percentile	HEDIS 2014 75th Percentile	Aetna Better Health Inc., an Illinois Corporation (Org ID: 15355, SubID: 11017, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Aetna Better Health of Texas (Org ID: 19734, SubID: 11018, Medicaid, Spec Area: Bexar, Spec Proj: TX Medicaid); Measurement Year - 2013	Aetna Better Health of Texas (Org ID: 19734, SubID: 11020, Medicaid, Spec Area: Tarrant, Spec Proj: TX Medicaid); Measurement Year - 2013	Aetna Better Health Inc., a Pennsylvania Corporation (Org ID: 14391, SubID: 10506, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Carilion Clinic Medicare Resources, LLC d/b/a MajestaCare Healthplan (Org ID: 16305, SubID: 11093, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	CHRISTUS Health Plan (Org ID: 21351, SubID: 11287, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	CoventryCares of Michigan (Org ID: 203, SubID: 4055, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Coventry Health Care of Florida, Inc. (Org ID: 300, SubID: 6650, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Coventry Health Care of Nebraska, Inc. (Org ID: 1797, SubID: 10501, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Coventry Health Care of Virginia, Inc. (Org ID: 315, SubID: 4368, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Coventry Health Care of West Virginia, Inc. (Org ID: 194, SubID: 4403, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Coventry Health & Life Insurance Company dba CoventryCares of Kentucky (Org ID: 19497, SubID: 10962, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Coventry Health Plan of Florida, Inc. (Org ID: 258, SubID: 4066, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Delaware Physicians Care, Incorporated (Org ID: 4534, SubID: 7136, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	HealthAmerica Pennsylvania, Inc. (Org ID: 1111, SubID: 10442, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	HealthCare USA of Missouri, LLC (Org ID: 1623, SubID: 11139, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Maryland Care Inc., d/b/a/ Maryland Physicians Care (Org ID: 1638, SubID: 6062, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Parkland Community Health Plan (Org ID: 19735, SubID: 11065, Medicaid, Spec Area: None, Spec Proj: None); Measurement Year - 2013	Average of Aetna Medicaid Scores	Does Average Score Exceed 2013 NCQA HMO National 50th Percentile for Medicaid Product Lines?	Does Average Score Exceed 2013 NCQA HMO National 75th Percentile for Medicaid Product Lines?
19-21 Years	**34.04%**	**41.02%**	20.05%	NB	NB	33.58%	NB	NB	NB	NR	NR	NB	NB	38.62%	NR	NB	30.22%	23.60%	NR	NB	29.21%	N	N
Total	**52.65%**	**61.13%**	20.00%	NB	NB	49.42%	NB	NB	NB	NR	NR	NB	NB	59.22%	NR	NB	43.21%	50.67%	NR	NB	44.50%	N	N
Initiation and Engagement of AOD Dependence Treatment (iet)																							
Initiation of AOD Treatment: 13-17 Years	**39.55%**	**47.47%**	NA	26.47%	42.86%	NB	NA	NA	NB	NA	NR	47.76%	NB	31.66%	NA	19.05%	NB	25.20%	38.85%	NR	33.12%	N	N
Engagement of AOD Treatment: 13-17 Years	**14.89%**	**23.88%**	NA	5.88%	14.29%	NB	NA	NA	NB	NA	NR	14.93%	NB	9.17%	NA	8.06%	NB	5.51%	22.05%	NR	11.41%	N	N
Initiation of AOD Treatment: 18+ Years	**37.98%**	**43.29%**	44.29%	36.00%	45.91%	NB	36.33%	23.73%	NB	33.96%	NR	38.21%	NB	31.47%	21.12%	36.38%	NB	33.97%	37.33%	NR	34.89%	N	N
Engagement of AOD Treatment: 18+ Years	**9.99%**	**14.17%**	7.75%	4.00%	14.47%	NB	6.94%	3.39%	NB	2.24%	NR	7.68%	NB	5.27%	1.24%	16.59%	NB	4.69%	19.83%	NR	7.84%	N	N
Initiation of AOD Treatment: Total	**37.49%**	**43.48%**	44.29%	33.03%	45.27%	NB	35.47%	24.00%	NB	33.57%	NR	39.25%	NB	31.48%	19.89%	35.36%	NB	32.82%	37.45%	NR	34.32%	N	N
Engagement of AOD Treatment: Total	**10.33%**	**14.97%**	7.75%	4.59%	14.43%	NB	7.17%	2.67%	NB	2.14%	NR	8.47%	NB	5.63%	1.14%	16.08%	NB	4.80%	20.01%	NR	7.91%	N	N
Prenatal and Postpartum Care (ppc)																							
Timeliness of Prenatal Care	**84.30%**	**89.62%**	69.70%	84.26%	90.72%	86.21%	86.35%	78.10%	84.35%	74.61%	91.00%	88.80%	92.71%	82.41%	73.91%	85.41%	86.85%	91.63%	84.92%	91.20%	84.62%	Y	N
Postpartum Care	**62.84%**	**69.47%**	54.55%	62.04%	66.59%	63.79%	59.58%	50.16%	66.12%	48.59%	63.75%	65.03%	60.55%	50.93%	48.55%	66.09%	62.68%	69.86%	71.93%	66.67%	60.97%	N	N
Call Answer Timeliness (cat)	**87.58%**	**91.85%**	NR	NR	NR	74.81%	94.50%	NR	85.59%	81.09%	86.15%	82.81%	82.14%	85.31%	81.09%	93.80%	84.50%	91.43%	89.16%	NR	85.57%	N	N
Utilization																							
Frequency of Ongoing Prenatal Care (fpc)																							
<21 Percent	**9.26%**	**15.71%**	NR	11.92%	12.20%	5.61%	NR	20.00%	20.23%	6.58%	7.46%	5.46%	3.77%	10.56%	7.25%	4.72%	8.45%	8.85%	5.60%	10.49%	9.32%	Y	N
21-40 Percent	**60.10%**	**71.34%**	NR	5.02%	3.90%	4.91%	NR	7.30%	13.95%	8.15%	5.14%	6.56%	3.02%	5.59%	7.25%	2.58%	3.99%	7.66%	3.65%	4.95%	5.85%	N	N
41-60 Percent	**5.40%**	**8.83%**	NR	7.49%	6.35%	5.84%	NR	12.70%	12.79%	16.93%	4.63%	6.28%	7.04%	9.72%	13.04%	5.58%	7.28%	5.26%	4.87%	8.93%	8.42%	Y	N
61-80 Percent	**7.71%**	**10.82%**	NR	18.50%	15.69%	15.19%	NR	15.87%	16.28%	19.44%	11.57%	6.83%	10.05%	20.40%	17.39%	12.66%	14.55%	12.68%	15.33%	17.48%	14.99%	Y	Y
81+ Percent	**14.79%**	**17.35%**	NR	57.07%	61.85%	68.46%	NR	44.13%	36.74%	48.90%	71.21%	74.86%	76.13%	53.73%	55.07%	74.46%	65.73%	65.55%	70.56%	58.15%	61.41%	Y	Y
Well-Child Visits in the First 15 Months of Life (w15)																							
0 Visits	**1.46%**	**2.64%**	NR	1.16%	2.85%	3.01%	0.00%	6.11%	2.23%	2.92%	2.55%	1.24%	0.29%	2.78%	1.49%	0.22%	4.98%	1.17%	0.48%	1.33%	2.05%	Y	N
1 Visit	**1.57%**	**2.35%**	NR	1.84%	3.07%	0.69%	1.84%	3.82%	2.97%	3.41%	0.46%	0.74%	2.34%	2.78%	1.79%	0.66%	1.56%	2.58%	1.20%	1.81%	1.97%	Y	N
2 Visits	**2.63%**	**3.70%**	NR	4.26%	5.43%	2.78%	1.84%	16.03%	3.96%	4.62%	2.55%	1.49%	2.63%	3.71%	3.27%	1.77%	1.87%	2.34%	1.93%	2.61%	3.71%	Y	Y
3 Visits	**4.87%**	**6.34%**	NR	5.13%	6.97%	2.55%	4.29%	12.98%	5.69%	10.22%	8.80%	6.44%	6.14%	6.73%	12.80%	4.19%	7.79%	5.85%	5.06%	5.06%	6.86%	Y	Y
4 Visits	**9.23%**	**11.88%**	NR	10.93%	13.50%	9.95%	10.43%	19.85%	16.58%	18.49%	14.81%	12.62%	8.19%	10.44%	17.26%	7.95%	12.46%	10.07%	7.71%	12.23%	12.56%	Y	Y
5 Visits	**16.01%**	**18.73%**	NR	16.92%	18.50%	17.82%	21.47%	17.56%	18.81%	23.11%	28.70%	16.09%	15.20%	15.78%	27.08%	15.89%	17.13%	15.46%	16.39%	22.19%	19.06%	Y	Y
6+ Visits	**62.86%**	**69.75%**	NR	59.77%	49.67%	63.19%	60.12%	23.66%	49.75%	37.23%	42.13%	61.39%	65.20%	57.77%	36.31%	69.32%	54.21%	62.53%	67.23%	54.76%	53.78%	N	N
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	**71.76%**	**77.26%**	NR	75.23%	69.44%	71.76%	65.34%	70.83%	74.73%	70.80%	63.19%	74.26%	73.73%	62.73%	81.71%	75.72%	75.42%	67.51%	88.81%	80.04%	73.01%	Y	N
Adolescent Well-Care Visits (awc)	**48.51%**	**59.21%**	25.82%	54.63%	46.53%	46.06%	37.53%	53.24%	57.52%	48.66%	50.94%	49.77%	47.20%	46.30%	62.27%	55.85%	56.94%	44.19%	68.75%	65.77%	51.00%	Y	N

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2010-2014 CAHPS All Plans Percentiles

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2010-2014 CAHPS All Plans Percentiles / 2014 CAHPS Adult Rates

	CAHPS Adult Survey Results								
Composite Rating Area	**Plan**	**HEDIS 2011 (CY 2010)**	**HEDIS 2012 (CY 2011)**	**HEDIS 2013 (CY 2012)**	**HEDIS 2014 (CY 2013)**	**2014 25th**	**2014 50th**	**2014 75th**	**2014 90th**
Getting Needed Care	Aetna Better Health - Illinois	NA	63.2	75.6	78.6	77.47	80.9	84.27	85.59
	Aetna Better Health - PA Medicaid	78	67.7	78.4	76.6	77.47	80.9	84.27	85.59
	Delaware Physician's Care, Inc.	84.1	85.2	85.2	90	77.47	80.9	84.27	85.59
	Mercy Care Plan - Medicaid	82.1	79.3	84	84.9	77.47	80.9	84.27	85.59
	CoventryCares from Health America	NA	79.74	88.31	82.6	77.47	80.9	84.27	85.59
	CoventryCares of West Virginia	76.93	74.01	92.66	80.47	77.47	80.9	84.27	85.59
	Coventry Health Care of Florida	74.83	80.95	86.83	75.94	77.47	80.9	84.27	85.59
	Coventry Health Plan of Florida	64.04	66.04	86.41	83.7	77.47	80.9	84.27	85.59
	Coventry Health Care of Kentucky	NA	NA	86.58	80.9	77.47	80.9	84.27	85.59
	Coventry Health Care of Michigan	81.25	81.33	90.8	77.52	77.47	80.9	84.27	85.59
	Coventry Health Care of Nebraska	76.54	77.02	85.08	84.97	77.47	80.9	84.27	85.59
	Coventry Health Care of Virginia	86.84	86.52	90.54	84.69	77.47	80.9	84.27	85.59
	NCQA Adult Medicaid National Average	75.95	75.5	80.62	80.45	77.47	80.9	84.27	85.59
Getting Care Quickly	Aetna Better Health - Illinois	NA	71.2	76.8	76.6	78.39	81.75	83.75	85.52
	Aetna Better Health - PA Medicaid	78.3	82.5	81.4	78.1	78.39	81.75	83.75	85.52
	Delaware Physician's Care, Inc.	85.8	80.3	85	83.5	78.39	81.75	83.75	85.52
	Mercy Care Plan - Medicaid	80.7	80.3	81.8	80.9	78.39	81.75	83.75	85.52
	CoventryCares from Health America	NA	76.52	80.58	78.95	78.39	81.75	83.75	85.52
	CoventryCares of West Virginia	77.83	79.31	83.88	80.89	78.39	81.75	83.75	85.52
	Coventry Health Care of Florida	74.77	82.82	78.24	78.73	78.39	81.75	83.75	85.52
	Coventry Health Plan of Florida	81.49	80.32	77.75	75.47	78.39	81.75	83.75	85.52
	Coventry Health Care of Kentucky	NA	NA	84.06	84.99	78.39	81.75	83.75	85.52
	Coventry Health Care of Michigan	84.62	79.92	84.94	83.09	78.39	81.75	83.75	85.52
	Coventry Health Care of Nebraska	83.65	85.77	84.38	87.28	78.39	81.75	83.75	85.52
	Coventry Health Care of Virginia	80.23	80.81	82.03	83.97	78.39	81.75	83.75	85.52
	NCQA Adult Medicaid National Average	80.56	80.33	81.16	81	78.39	81.75	83.75	85.52
How Well Doctors Communicate	Aetna Better Health - Illinois	NA	85	89.7	87.8	88.16	89.76	91.11	92.42
	Aetna Better Health - PA Medicaid	87.6	88	91.7	90.7	88.16	89.76	91.11	92.42
	Delaware Physician's Care, Inc.	89.8	90.5	91.3	92.6	88.16	89.76	91.11	92.42
	Mercy Care Plan - Medicaid	90.2	88.6	87.4	89.5	88.16	89.76	91.11	92.42
	CoventryCares from Health America	NA	85.21	90.83	89.64	88.16	89.76	91.11	92.42
	CoventryCares of West Virginia	90.49	85.04	92.01	87.96	88.16	89.76	91.11	92.42
	Coventry Health Care of Florida	86.94	84.42	91.62	86.87	88.16	89.76	91.11	92.42
	Coventry Health Plan of Florida	91.67	91.04	92.61	94.39	88.16	89.76	91.11	92.42
	Coventry Health Care of Kentucky	NA	NA	90.73	88.71	88.16	89.76	91.11	92.42
	Coventry Health Care of Michigan	87.9	85.33	87.24	86.17	88.16	89.76	91.11	92.42
	Coventry Health Care of Nebraska	91.01	92.26	92.07	92.94	88.16	89.76	91.11	92.42
	Coventry Health Care of Virginia	90.04	89.46	88.78	90.83	88.16	89.76	91.11	92.42
	NCQA Adult Medicaid National Average	87.84	87.81	89.27	89.49	88.16	89.76	91.11	92.42
Customer Service	Aetna Better Health - Illinois	NA	78	80.2	82.9	84.45	87.05	88.64	90.28
	Aetna Better Health - PA Medicaid	79.3	83.5	84.7	83.8	84.45	87.05	88.64	90.28
	Delaware Physician's Care, Inc.	86.8	85.1	87.8	89.2	84.45	87.05	88.64	90.28
	Mercy Care Plan - Medicaid	82.9	83.9	87.3	87.1	84.45	87.05	88.64	90.28
	CoventryCares from Health America	NA	79.74	88.35	84.47	84.45	87.05	88.64	90.28
	CoventryCares of West Virginia	76.93	74.01	92.66	88.71	84.45	87.05	88.64	90.28
	Coventry Health Care of Florida	74.83	80.95	86.83	88.84	84.45	87.05	88.64	90.28
	Coventry Health Plan of Florida	64.04	66.04	86.41	92.15	84.45	87.05	88.64	90.28
	Coventry Health Care of Kentucky	NA	NA	86.58	79.53	84.45	87.05	88.64	90.28
	Coventry Health Care of Michigan	81.25	81.33	90.8	87.73	84.45	87.05	88.64	90.28
	Coventry Health Care of Nebraska	76.54	77.02	85.08	85.43	84.45	87.05	88.64	90.28
	Coventry Health Care of Virginia	86.84	86.52	90.54	88.63	84.45	87.05	88.64	90.28
	NCQA Adult Medicaid National Average	79.74	80.42	86.16	86.51	84.45	87.05	88.64	90.28

2010-2014 CAHPS All Plans Percentiles / 2014 CAHPS Adult Rates

	CAHPS Adult Survey Results								
Composite Rating Area	**Plan**	**HEDIS 2011 (CY 2010)**	**HEDIS 2012 (CY 2011)**	**HEDIS 2013 (CY 2012)**	**HEDIS 2014 (CY 2013)**	**2014 25th**	**2014 50th**	**2014 75th**	**2014 90th**
Ratings	**Plan**	**HEDIS 2011 (CY 2010)**	**HEDIS 2012 (CY 2011)**	**HEDIS 2013 (CY 2012)**	**HEDIS 2014 (CY 2013)**	**2014 25th**	**2014 50th**	**2014 75th**	**2014 90th**
Rating of Personal Doctor	Aetna Better Health - Illinois	NA	73.1	78.1	74.4	76.45	78.82	80.97	83.1
	Aetna Better Health - PA Medicaid	68	76.6	75.7	81	76.45	78.82	80.97	83.1
	Delaware Physician's Care, Inc.	77.8	77	79.1	80.8	76.45	78.82	80.97	83.1
	Mercy Care Plan - Medicaid	76.7	76.3	72.9	77.3	76.45	78.82	80.97	83.1
	CoventryCares from Health America	NA	75	75.53	78.93	76.45	78.82	80.97	83.1
	CoventryCares of West Virginia	74.89	74.73	79.72	75.44	76.45	78.82	80.97	83.1
	Coventry Health Care of Florida	76.02	76.1	78.31	79.51	76.45	78.82	80.97	83.1
	Coventry Health Plan of Florida	82.05	87.59	88.44	84.39	76.45	78.82	80.97	83.1
	Coventry Health Care of Kentucky	NA	NA	77.53	81.92	76.45	78.82	80.97	83.1
	Coventry Health Care of Michigan	77.9	75.53	80.95	77.54	76.45	78.82	80.97	83.1
	Coventry Health Care of Nebraska	79.14	86.27	80.26	83	76.45	78.82	80.97	83.1
	Coventry Health Care of Virginia	76.03	76.09	78.74	82.86	76.45	78.82	80.97	83.1
	NCQA Adult Medicaid National Average	76.44	77.08	78.36	78.75	76.45	78.82	80.97	83.1
Rating of Specialist	Aetna Better Health - Illinois	NA	75.1	76.7	79.8	78.64	80.61	82.47	85.31
	Aetna Better Health - PA Medicaid	83.5	74.8	75.9	78.5	78.64	80.61	82.47	85.31
	Delaware Physician's Care, Inc.	79.2	83	76.6	86	78.64	80.61	82.47	85.31
	Mercy Care Plan - Medicaid	80.6	79.7	78.5	76.2	78.64	80.61	82.47	85.31
	CoventryCares from Health America	NA	68.42	77.7	80.12	78.64	80.61	82.47	85.31
	CoventryCares of West Virginia	72.92	77.11	73.85	73.49	78.64	80.61	82.47	85.31
	Coventry Health Care of Florida	73.75	84.42	81.11	85.87	78.64	80.61	82.47	85.31
	Coventry Health Plan of Florida	76.04	75.36	85.85	86.14	78.64	80.61	82.47	85.31
	Coventry Health Care of Kentucky	NA	NA	80.37	75.48	78.64	80.61	82.47	85.31
	Coventry Health Care of Michigan	77.6	74.14	84.03	79.1	78.64	80.61	82.47	85.31
	Coventry Health Care of Nebraska	76.73	76.13	85.47	77.01	78.64	80.61	82.47	85.31
	Coventry Health Care of Virginia	80.56	80.33	73.43	86.62	78.64	80.61	82.47	85.31
	NCQA Adult Medicaid National Average	76.85	77.66	79.37	80.42	78.64	80.61	82.47	85.31
Rating of All Health Care	Aetna Better Health - Illinois	NA	57.4	63.5	64.1	68.54	71.53	74.06	76.95
	Aetna Better Health - PA Medicaid	68.4	65.9	72.5	71.5	68.54	71.53	74.06	76.95
	Delaware Physician's Care, Inc.	72.3	73.2	74.9	79.4	68.54	71.53	74.06	76.95
	Mercy Care Plan - Medicaid	71.8	72.1	72.2	73.9	68.54	71.53	74.06	76.95
	CoventryCares from Health America	NA	69.83	70.99	73.36	68.54	71.53	74.06	76.95
	CoventryCares of West Virginia	66.94	67.49	75.33	65.38	68.54	71.53	74.06	76.95
	Coventry Health Care of Florida	60.71	73.72	70	72.08	68.54	71.53	74.06	76.95
	Coventry Health Plan of Florida	71.53	76.61	79.75	79.12	68.54	71.53	74.06	76.95
	Coventry Health Care of Kentucky	NA	NA	67.98	69.1	68.54	71.53	74.06	76.95
	Coventry Health Care of Michigan	63.21	65.22	71.43	67.69	68.54	71.53	74.06	76.95
	Coventry Health Care of Nebraska	71.81	78.1	73.85	76.95	68.54	71.53	74.06	76.95
	Coventry Health Care of Virginia	74.84	72.12	69.97	71.53	68.54	71.53	74.06	76.95
	NCQA Adult Medicaid National Average	68.9	69.88	70.84	71.26	68.54	71.53	74.06	76.95
Rating of Health Plan	Aetna Better Health - Illinois	NA	58.4	57.5	65.1	71.37	75.52	78.77	81.49
	Aetna Better Health - PA Medicaid	57.9	66.9	64.8	66.6	71.37	75.52	78.77	81.49
	Delaware Physician's Care, Inc.	80.1	76.8	75.7	79.6	71.37	75.52	78.77	81.49
	Mercy Care Plan - Medicaid	80	76.9	76.1	78.7	71.37	75.52	78.77	81.49
	CoventryCares from Health America	NA	70.37	69.72	71.47	71.37	75.52	78.77	81.49
	CoventryCares of West Virginia	65.26	65.88	65.97	65.18	71.37	75.52	78.77	81.49
	Coventry Health Care of Florida	64.42	79.65	65.77	71.9	71.37	75.52	78.77	81.49
	Coventry Health Plan of Florida	66.29	72.73	77.83	76.23	71.37	75.52	78.77	81.49
	Coventry Health Care of Kentucky	NA	NA	66.03	70.88	71.37	75.52	78.77	81.49
	Coventry Health Care of Michigan	75.56	76.36	76.53	75.72	71.37	75.52	78.77	81.49
	Coventry Health Care of Nebraska	67.05	71.12	72.69	77.47	71.37	75.52	78.77	81.49
	Coventry Health Care of Virginia	78.55	77.12	75.8	82.86	71.37	75.52	78.77	81.49
	NCQA Adult Medicaid National Average	72.45	73.46	73.53	74.67	71.37	75.52	78.77	81.49

2010-2014 CAHPS All Plans Percentiles / 2014 CAHPS Child Rates

CAHPS Child Survey Results										
Composite Rating Area	**Plan**	**HEDIS 2011 (CY 2010)**	**HEDIS 2012 (CY 2011)**	**HEDIS 2013 (CY 2012)**	**HEDIS 2014 (CY 2013)**	**2014 25th**	**2014 50th**	**2014 75th**	**2014 90th**	**2014 Results**
Getting Needed Care	Aetna Better Health - PA Medicaid	69.5	73.5	81.9	87.7	82.62	85.44	87.9	90.71	50th
	Aetna Better Health - PA CHIP	86.4	83.5	85.7	82.7	82.62	85.44	87.9	90.71	25th
	Delaware Physician's Care, Inc	86.1	83.6	84.9	86.8	82.62	85.44	87.9	90.71	50th
	Mercy Care Plan - Medicaid	85	82.9	83	87.9	82.62	85.44	87.9	90.71	75th
	TXA Bexar	NA	NA	NA	82.4	82.62	85.44	87.9	90.71	<25th
	TXA Tarrant	NA	NA	NA	77.8	82.62	85.44	87.9	90.71	<25th
	TXP (ASO)	NA	NA	NA	83.9	82.62	85.44	87.9	90.71	25th
	Coventry Health Care of KY - Medicaid	NA	NA	90.61	90.86	82.62	85.44	87.9	90.71	90th
	Coventry Health Care of NE - Medicaid	NA	86.91	90.51	91.28	82.62	85.44	87.9	90.71	90th
	Coventry Health Care of VA - Medicaid	80.9	83.58	87.07	87.9	82.62	85.44	87.9	90.71	75th
	Coventry PA	NA	NA	83.08	84.25	82.62	85.44	87.9	90.71	25th
	Coventry WV	NA	NA	94.05	90.29	82.62	85.44	87.9	90.71	75th
	Healthcare USA - Medicaid	81.33	81.05	86.72	89.84	82.62	85.44	87.9	90.71	75th
	NCQA Child Medicaid National Average	**79.28**	**79.25**	**84.38**	**84.97**	**82.62**	**85.44**	**87.9**	**90.71**	25th
Getting Care Quickly	Aetna Better Health - PA Medicaid	87.4	87.4	89.6	91.7	87.67	90.59	92.45	93.81	50th
	Aetna Better Health - PA CHIP	91.2	90.9	91	90.3	87.67	90.59	92.45	93.81	25th
	Delaware Physician's Care, Inc	88	92.8	94.6	90.2	87.67	90.59	92.45	93.81	25th
	Mercy Care Plan - Medicaid	87.5	88.3	88.2	90.5	87.67	90.59	92.45	93.81	25th
	TXA Bexar	NA	NA	NA	88.3	87.67	90.59	92.45	93.81	25th
	TXA Tarrant	NA	NA	NA	90.3	87.67	90.59	92.45	93.81	25th
	TXP (ASO)	NA	NA	NA	86.4	87.67	90.59	92.45	93.81	<25th
	Coventry Health Care of KY - Medicaid	NA	NA	94.27	94.03	87.67	90.59	92.45	93.81	90th
	Coventry Health Care of NE - Medicaid	NA	91.51	91.74	93.7	87.67	90.59	92.45	93.81	75th
	Coventry Health Care of VA - Medicaid	87.42	85.89	92.46	91.29	87.67	90.59	92.45	93.81	50th
	Coventry PA	NA	NA	89.93	91.74	87.67	90.59	92.45	93.81	50th
	Coventry WV	NA	NA	94.67	95.09	87.67	90.59	92.45	93.81	90th
	Healthcare USA - Medicaid	91.87	91.09	93.4	94.65	87.67	90.59	92.45	93.81	90th
	NCQA Child Medicaid National Average	87.2	87.28	89.19	89.46	87.67	90.59	92.45	93.81	25th
How Well Doctors Communicate	**Aetna Better Health - PA Medicaid**	90.5	91.6	94.1	95.2	91.96	93.25	94.67	95.61	75th
	Aetna Better Health - PA CHIP	96.4	95.5	95.2	95.6	91.96	93.25	94.67	95.61	75th
	Delaware Physician's Care, Inc	90.9	92.8	93.3	94.5	91.96	93.25	94.67	95.61	50th
	Mercy Care Plan - Medicaid	90.7	92.5	92.8	92.5	91.96	93.25	94.67	95.61	25th
	TXA Bexar	NA	NA	NA	90.5	91.96	93.25	94.67	95.61	<25th
	TXA Tarrant	NA	NA	NA	90.5	91.96	93.25	94.67	95.61	<25th
	TXP (ASO)	NA	NA	NA	89.6	91.96	93.25	94.67	95.61	<25th
	Coventry Health Care of KY - Medicaid	NA	NA	93.37	94.99	91.96	93.25	94.67	95.61	75th
	Coventry Health Care of NE - Medicaid	NA	91.59	94.44	95.67	91.96	93.25	94.67	95.61	90th
	Coventry Health Care of VA - Medicaid	91.89	94.27	95.42	93.93	91.96	93.25	94.67	95.61	50th
	Coventry PA	NA	NA		95.72	91.96	93.25	94.67	95.61	90th
	Coventry WV	NA	NA		94.81	91.96	93.25	94.67	95.61	75th
	Healthcare USA - Medicaid			94.09	94.81	91.96	93.25	94.67	95.61	75th
	NCQA Child Medicaid National Average	91.57	91.79	92.61	92.98	91.96	93.25	94.67	95.61	25th
Customer Service	Aetna Better Health - PA Medicaid	74.8	78.9	85	88.8	85.98	88.13	89.91	91.03	50th
	Aetna Better Health - PA CHIP	80.5	86	84.9	87.5	85.98	88.13	89.91	91.03	25th
	Delaware Physician's Care, Inc	83.3	87	88.3	85.2	85.98	88.13	89.91	91.03	<25th
	Mercy Care Plan - Medicaid	88.7	84.5	87.9	89.6	85.98	88.13	89.91	91.03	50th
	TXA Bexar	NA	NA	NA	89.3	85.98	88.13	89.91	91.03	50th
	TXA Tarrant	NA	NA	NA	89.8	85.98	88.13	89.91	91.03	50th
	TXP (ASO)	NA	NA	NA	90.5	85.98	88.13	89.91	91.03	75th
	Coventry Health Care of KY - Medicaid	NA	NA	88.99	87.9	85.98	88.13	89.91	91.03	25th
	Coventry Health Care of NE - Medicaid	NA	80.24	93.54	88.04	85.98	88.13	89.91	91.03	25th
	Coventry Health Care of VA - Medicaid	85.85	84.98	91.3	88.16	85.98	88.13	89.91	91.03	50th
	Coventry PA	NA	NA	85.95	88.99	85.98	88.13	89.91	91.03	50th
	Coventry WV	NA	NA	93.47	93.82	85.98	88.13	89.91	91.03	90th
	Healthcare USA - Medicaid	85.8	83.15	91.21	91.91	85.98	88.13	89.91	91.03	90th
	NCQA Child Medicaid National Average	81.14	83.02	87.61	87.89	85.98	88.13	89.91	91.03	25th

2010-2014 CAHPS All Plans Percentiles / 2014 CAHPS Child Rates

CAHPS Child Survey Results										
Composite Rating Area	**Plan**	**HEDIS 2011 (CY 2010)**	**HEDIS 2012 (CY 2011)**	**HEDIS 2013 (CY 2012)**	**HEDIS 2014 (CY 2013)**	**2014 25th**	**2014 50th**	**2014 75th**	**2014 90th**	**2014 Results**
Ratings	**Plan**	**HEDIS 2011 (CY 2010)**	**HEDIS 2012 (CY 2011)**	**HEDIS 2013 (CY 2012)**	**HEDIS 2014 (CY 2013)**	**2014 25th**	**2014 50th**	**2014 75th**	**2014 90th**	90th
Ratings of Personal Doctor	Aetna Better Health - PA Medicaid	80.9	83.9	84.7	87.3	85.89	87.84	89.43	90.93	25th
	Aetna Better Health - PA CHIP	87.5	89.4	88.5	86.5	85.89	87.84	89.43	90.93	25th
	Delaware Physician's Care, Inc	88.4	89.1	90.4	92.5	85.89	87.84	89.43	90.93	90th
	Mercy Care Plan - Medicaid	84	89.6	91.1	88.1	85.89	87.84	89.43	90.93	50th
	TXA Bexar	NA	NA	NA	84.6	85.89	87.84	89.43	90.93	<25th
	TXA Tarrant	NA	NA	NA	84.5	85.89	87.84	89.43	90.93	<25th
	TXP (ASO)	NA	NA	NA	84.9	85.89	87.84	89.43	90.93	<25th
	Coventry Health Care of KY - Medicaid	NA	NA	88.45	85.8	85.89	87.84	89.43	90.93	<25th
	Coventry Health Care of NE - Medicaid	NA	85.83	90.22	87.74	85.89	87.84	89.43	90.93	25th
	Coventry Health Care of VA - Medicaid	87.57	88.68	86.29	85.9	85.89	87.84	89.43	90.93	25th
	Coventry PA	NA	NA	85.28	89.18	85.89	87.84	89.43	90.93	50th
	Coventry WV	NA	NA	87.04	91.38	85.89	87.84	89.43	90.93	90th
	Healthcare USA - Medicaid	86.86	85.84	86.34	88.67	85.89	87.84	89.43	90.93	50th
	NCQA Child Medicaid National Average	84.9	86.44	87.1	87.63	85.89	87.84	89.43	90.93	25th
Rating of Specialist	**Aetna Better Health - PA Medicaid**	78.1	77.6	86.3	87.4	83.06	85.01	87.36	89.5	75th
	Aetna Better Health - PA CHIP	82.5	87.9	79.7	86.9	83.06	85.01	87.36	89.5	50th
	Delaware Physician's Care, Inc	88.2	83.2	84.8	87.5	83.06	85.01	87.36	89.5	75th
	Mercy Care Plan - Medicaid	84.9	80	82.1	84.3	83.06	85.01	87.36	89.5	25th
	TXA Bexar	NA	NA	NA	84.9	83.06	85.01	87.36	89.5	25th
	TXA Tarrant	NA	NA	NA	82.1	83.06	85.01	87.36	89.5	<25th
	TXP (ASO)	NA	NA	NA	84.9	83.06	85.01	87.36	89.5	25th
	Coventry Health Care of KY - Medicaid	NA	NA	89.44	87.96	83.06	85.01	87.36	89.5	75th
	Coventry Health Care of NE - Medicaid	NA	75.86	89.66	90.54	83.06	85.01	87.36	89.5	90th
	Coventry Health Care of VA - Medicaid	77.27	78.95	79.78	79.59	83.06	85.01	87.36	89.5	<25th
	Coventry PA	NA	NA	83.54	82.8	83.06	85.01	87.36	89.5	<25th
	Coventry WV	NA	NA	91.3	86.75	83.06	85.01	87.36	89.5	50th
	Healthcare USA - Medicaid	85.67	82.3	82.14	85.2	83.06	85.01	87.36	89.5	50th
	NCQA Child Medicaid National Average	82.54	82.35	84.52	85.02	83.06	85.01	87.36	89.5	50th
Rating of all Health Care	Aetna Better Health - PA Medicaid	76.5	80.1	81.1	84.2	82.63	84.7	86.65	88.85	25th
	Aetna Better Health - PA CHIP	87.2	85.7	85.9	80.2	82.63	84.7	86.65	88.85	<25th
	Delaware Physician's Care, Inc	84.8	83.2	85.6	86.1	82.63	84.7	86.65	88.85	50th
	Mercy Care Plan - Medicaid	82.2	85.1	88	86.4	82.63	84.7	86.65	88.85	50th
	TXA Bexar	NA	NA	NA	85	82.63	84.7	86.65	88.85	50th
	TXA Tarrant	NA	NA	NA	85.3	82.63	84.7	86.65	88.85	50th
	TXP (ASO)	NA	NA	NA	86.7	82.63	84.7	86.65	88.85	75th
	Coventry Health Care of KY - Medicaid	NA	NA	79.87	79.81	82.63	84.7	86.65	88.85	<25th
	Coventry Health Care of NE - Medicaid	NA	84.1	87.14	87.63	82.63	84.7	86.65	88.85	75th
	Coventry Health Care of VA - Medicaid	79.81	86.24	84.98	83.39	82.63	84.7	86.65	88.85	25th
	Coventry PA	NA	NA	81.49	82.63	82.63	84.7	86.65	88.85	25th
	Coventry WV	NA	NA	84.97	89.39	82.63	84.7	86.65	88.85	90th
	Healthcare USA - Medicaid	86.56	84.37	87.45	88	82.63	84.7	86.65	88.85	75th
	NCQA Child Medicaid National Average	81.51	83.04	83.12	84.7	82.63	84.7	86.65	88.85	50th
Rating of Health Plan	Aetna Better Health - PA Medicaid	67.1	75.2	78.2	78.9	81.85	84.83	87.45	88.66	<25th
	Aetna Better Health - PA CHIP	81.2	82.5	81	74.9	81.85	84.83	87.45	88.66	<25th
	Delaware Physician's Care, Inc	86.7	86.6	86.7	84.8	81.85	84.83	87.45	88.66	25th
	Mercy Care Plan - Medicaid	85.4	87.9	90.8	87.8	81.85	84.83	87.45	88.66	75th
	TXA Bexar	NA	NA	NA	87.6	81.85	84.83	87.45	88.66	75th
	TXA Tarrant	NA	NA	NA	88.5	81.85	84.83	87.45	88.66	75th
	TXP (ASO)	NA	NA	NA	90.3	81.85	84.83	87.45	88.66	90th
	Coventry Health Care of KY - Medicaid	NA	NA	80.46	79.54	81.85	84.83	87.45	88.66	<25th
	Coventry Health Care of NE - Medicaid	NA	80.63	83.64	82.61	81.85	84.83	87.45	88.66	25th
	Coventry Health Care of VA - Medicaid	84.27	86.61	83.24	84.69	81.85	84.83	87.45	88.66	25th
	Coventry PA	NA	NA	76.69	78.65	81.85	84.83	87.45	88.66	<25th
	Coventry WV	NA	NA	85.33	87.44	81.85	84.83	87.45	88.66	50th
	Healthcare USA - Medicaid	86.66	85.14	84.14	87.43	81.85	84.83	87.45	88.66	50th
	NCQA Child Medicaid National Average	82.14	83.72	82.89	84.49	81.85	84.83	87.45	88.66	25th

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Appendix W

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6.1.2 (Q2) Sample Provider Agreements

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Aetna Better Health of Iowa
Provider Group Agreement

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Aetna Better Health of Iowa

Medicaid Provider Group Agreement Checklist

_____ **All** pages of this document must be printed and returned to Aetna Better Health (not just the signature pages).

_____ **Page 1**. The Provider Group name that is filled in on the top of page one must match **exactly** with the name on the W9. **Leave the effective date blank**. This will be filled in by Aetna Better Health.

_____ **Signature Page**. The signature page must be signed by an appropriate Provider Group representative. The other information (TIN, NPI, and Reimbursement Address) must be completely filled in.

_____ **Individual Provider Addendum**. The Provider Group name that is filled in on the top must match **exactly** with the name on the W9. The Addendum must be signed by the appropriate Provider, dated and include the Provider's NPI Number. The Group may also choose to complete and submit Aetna Better Health's provider roster template in lieu of the Individual Provider Addendum.

_____ **Provider Application**. The Aetna Better Health Provider Application must be returned with the contract.

_____ **W9**. A W9 form must be returned with the contract. As indicated above, the name on the W9 must match exactly the name listed on pages 1 and the signature page of the Agreement.

Please return all documents to:

Aetna Better Health of Iowa
Attn: Network Management
4320 NW 114th Street
Urbandale, IA 50322

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AETNA BETTER HEALTH OF IOWA
PROVIDER GROUP AGREEMENT

The term of this Medicaid Provider Group Agreement (the "Agreement") by and between Aetna Better Health of Iowa Inc., an Iowa corporation on behalf of itself and its Affiliates (hereinafter "Company"), and _____ (hereinafter "Group"), shall commence effective _____, 20___ [Date to be completed by Company] (the "Effective Date"). Company and Provider may be referred to individually as a "Party" and collectively as the "Parties." The Regulatory Compliance Addendum (Exhibit A) and Medicare Compliance Addendum (Exhibit D, including Schedule 1) attached to this Agreement, are expressly incorporated into this Agreement and are binding upon the Parties. In the event of any inconsistent or contrary language between the Addenda and any other part of this Agreement, including but not limited to exhibits, attachments or amendments, the Parties agree that the provisions of the Addenda shall prevail.

WHEREAS, Company administers Plans for Government Sponsors that provide access to health care services to Members or arranges for the provision of health care services to Members of Government Programs; and

WHEREAS, Company contracts with certain health care providers and facilities to provide access to such health care services to Members; and

WHEREAS, Participating Group Providers provide health care services to patients within the scope of their licensure or accreditation; and

WHEREAS, Company and Group mutually desire to enter into an arrangement whereby Group and Participating Group Providers will become Participating Providers and will render health care services to Members; and

WHEREAS, in return for the provision of health care services by Participating Group Providers, Company will pay Group for Covered Services under the terms of this Agreement; and

WHEREAS, Group understands and agrees that Government Sponsors or other government entities may require certain changes to the terms of this Agreement before Group and Participating Group Providers can provide services to Members under the terms of any Plans that are awarded, by the Government Sponsors, to Company.

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants, promises and undertakings herein, the sufficiency of which is hereby acknowledged, and intending to be legally bound hereby, the parties agree as follows:

1.0 DEFINITIONS

When used in this Agreement, all capitalized terms shall have the following meanings:

Affiliate. Any corporation, partnership or other legal entity directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company.

Clean Claim. A claim that can be processed without obtaining additional information from the Group who provided the service or from a third party, except that it shall not mean a claim submitted by or on behalf of a Group who is under investigation for fraud or abuse, or a claim that is under review for medical necessity; provided, further, unless otherwise required by law or regulation, a claim which (a) is submitted within the proper timeframe as set forth in this Agreement and (b) has (i) detailed and descriptive medical and patient data, (ii) a corresponding referral (whether in paper or electronic format), if required for the applicable claim, (iii) whether submitted via an electronic transaction using permitted standard code sets (e.g., CPT-4, ICD-9 (or successor standard), HCPCS) as required by the applicable Federal or state regulatory authority (e.g., U.S. Dept. of Health & Human Services, U.S. Dept. of Labor, state law or regulation) or otherwise, all the data elements of the UB-04 or CMS-1500 (or successor standard) forms (including but not limited to Member identification number, national provider identifier ("NPI"), date(s) of service, complete and accurate breakdown of services), and (c) does not involve coordination of benefits,

and (d) has no defect or error (including any new procedures with no CPT code, experimental procedures or other circumstances not contemplated at the time of execution of this Agreement) that prevents timely adjudication.

Coinsurance. A payment a Member is required to make under a Plan which is determined as a percentage of the lesser of: (a) the rates established under this Agreement; or (b) Participating Group Provider's usual, customary and reasonable billed charges.

Company. Aetna Better Health of Iowa, Inc.

Confidential Information. Any information that identifies a Member and is related to the Member's participation in a Plan, the Member's physical or mental health or condition, the provision of health care to the Member or payment for the provision of health care to the Member. Confidential Information includes, without limitation, "individually identifiable health information," as defined in 45 C.F.R. § 160.103 and "non-public personal information" as defined in laws or regulations promulgated under the Gramm-Leach-Bliley Act of 1999.

Copayment. A charge required under a Plan that must be paid by a Member at the time of the provision of Covered Services, or at such other time as determined by Participating Group Provider and which is expressed as a specific dollar amount.

Covered Services. Those health care services for which a Member is entitled to receive coverage under the terms and conditions of a Plan. The Parties agree that Company is obligated to pay for only those Covered Services that are determined to be medically necessary, as determined in accordance with the Member's applicable Plan.

Covering Provider. A Participating Provider designated by a Participating Group Provider to provide Covered Services to Members when a Participating Group Provider is unavailable (e.g. out of the office or on vacation).

Deductible. An amount that a Member must pay for Covered Services during a specified coverage period in accordance with the Member's Plan before benefits will be paid.

Effective Date. Defined in first paragraph of this Agreement.

Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, her pregnancy or health or the health of her fetus) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part; or such other definition as may be required by applicable law.

Emergency Services. Covered Services furnished by a qualified provider and necessary to evaluate or stabilize an Emergency Medical Condition.

Government Programs. Plans operated and/or administered by Company pursuant to a State Contract.

Government Sponsor. A state agency or other governmental entity authorized to offer, issue and/or administer one or more Plans, and which, to the extent applicable, has contracted with Company to administer all or a portion of such Plan(s).

Group. Defined in first paragraph of this Agreement.

Group Provider. A duly licensed and qualified physician who is employed by, or who is a partner or shareholder, of Group.

Initial Term. Defined in Section 6.1 of this Agreement.

Material Change. Any change in Policies that could reasonably be expected, in Company's determination, to have a material adverse impact on (i) Group's reimbursement for Provider Services or (ii) administration of Group's practice.

Medically Necessary or Medical Necessity. Health care services that a physician or other applicable health care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendation and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member. An individual covered by or enrolled in a Plan.

Participating Provider. Any physician, hospital, hospital-based physician, skilled nursing facility, mental health and/or substance abuse professional (which shall include psychiatrists, psychologists, social workers, psychiatric nurses, counselors, family or other therapists or other mental health/substance abuse professionals), or other individual or entity involved in the delivery of health care or ancillary services who or which has entered into and continues to have a current valid contract with Company to provide Covered Services to Members, and, where applicable, has been credentialed by Company or its designee consistent with the credentialing policies of Company or its designee, as applicable. Certain categories of Participating Providers may be referred to herein more specifically as, e.g., "Participating Physicians" or "Participating Hospitals."

Participating Group Provider. A Group Provider who has been accepted as a Participating Provider by Company.

Party. Company or Group and Participating Group Providers, as applicable. Company and Participating Group Providers may be referred to collectively as the "Parties."

Provider Services. Defined in Section 2.1 of this Agreement.

Plan. A Member's health care benefits as set forth in the State Contract. Such Plans are listed in the **Program Participation Schedule** attached hereto and made a part hereof.

Policies. The policies and procedures promulgated by Company which relate to the duties and obligations of the Parties under the terms of this Agreement, including, but not limited to: (a) quality improvement/management; (b) utilization management, including, but not limited to, precertification of elective admissions and procedures, concurrent review of services and referral processes or protocols; (c) pre-admission testing guidelines; (d) claims payment review; (e) member grievances; (f) Provider credentialing; (g) electronic submission of claims and other data required by Company; and (h) any applicable participation criteria required by the State in connection with the Government Programs. Policies also include those policies and procedures set forth in the Company's and/or Government Sponsor's manuals (as modified from time to time) as Company determines appropriate in its sole discretion; clinical policy bulletins made available via Company's internet web site; and other policies and procedures, whether made available via a password-protected web site for Participating Providers (when available), by letter, newsletter, electronic mail or other media.

Post-Stabilization Care Services. Covered Services relating to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, under circumstances defined in federal regulations, to improve or resolve the Member's condition, pursuant to 42 CFR §422.113(c)(1), Social Security Act §1852(d)(2) and 42 CFR §438.114(a).

Proprietary Information. Any and all information, whether prepared by a Party, its advisors or otherwise, relating to such Party or the development, execution or performance of this Agreement whether furnished prior to or after the Effective Date. Proprietary Information includes but is not limited to, with respect to Company, the development of a pricing structure, (whether written or oral) all financial information, rate schedules and financial terms which relate to Group and which are furnished or disclosed to Group by Company. Notwithstanding the foregoing, the following shall not constitute Proprietary Information:

(a) information which was known to a receiving Party (a "Recipient") prior to receipt from the other Party (a "Disclosing Party") (as evidenced by the written records of a Recipient);

(b) information which was previously available to the public prior to a Recipient's receipt thereof from a Disclosing Party;

(c) information which subsequently became available to the public through no fault or omission on the part of a Recipient, including without limitation, the Recipient's officers, directors, trustees, employees, agents, contractors and other representatives;

(d) information which is furnished to a Recipient by a third party which a Recipient confirms, after due inquiry, has no confidentiality obligation, directly or indirectly, to a Disclosing Party; or

(e) information which is approved in writing in advance for disclosure or other use by a Disclosing Party.

Specialty Program. A program for a targeted group of Members with certain types of illnesses, conditions, cost or risk factors.

Specialty Program Providers. Those hospitals, physicians and other providers that have been identified or designated by Company or the Government Sponsor to provide Covered Services associated with a Specialty Program.

State Contract. Company's contract(s) with Government Sponsors to administer Plans or Government Programs identified in the **Program Participation Schedule**.

2.0 GROUP AND PARTICIPATING GROUP PROVIDER SERVICES AND OBLIGATIONS

2.1 Provision of Services.
Group shall provide to Members, through Participating Group Providers, those Covered Services which are within the scope of the respective Participating Group Provider's license and certification to practice ("Provider Services"). Participating Group Providers may not provide any Covered Services to Members unless and until Participating Group Providers have been fully credentialed and approved by Company or its designee.

2.2 Non-Discrimination and Equitable Treatment of Members.
Group and Participating Group Providers agree to provide Provider Services to Members with the same degree of care and skill as customarily provided to Participating Group Providers' patients who are not Members, according to generally accepted standards of practice. Group and Participating Group Providers and Company agree that Members and non-Members should be treated equitably. Group and Participating Group Providers agree not to discriminate against Members on the basis of race, ethnicity, gender, creed, ancestry, lawful occupation, age, religion, marital status, sexual orientation, mental or physical disability, color, national origin, place of residence, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, health status, source of payment for services, cost or extent of Provider Services required, or any other grounds prohibited by law or this Agreement and will abide by Company's cultural competency Policies. Group shall deliver Covered Services in a culturally competent manner to Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds, and comply with Company's Policies on cultural competency.

2.3 Federal Law.

Company is a Federal contractor and an Equal Opportunity Employer which maintains an Affirmative Action Program. To the extent applicable to Provider, Provider, on behalf of itself and any subcontractors, agrees to comply with the following, as amended from time to time: Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq., and regulations promulgated thereunder, Executive Order 11246, the Vietnam Era Veterans Readjustment Act of 1974, the Drug Free Workplace Act of 1988, Section 503 of the Rehabilitation Act of 1973, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") administrative simplification rules at 45 CFR parts 160, 162, and 164, the Americans with Disabilities Act of 1990, Federal laws, rules and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (Section 1128B(b) of the Social Security Act) and any similar laws, regulations or other legal mandates applicable to recipients of federal funds and/or transactions under or otherwise subject to any government contract of Company.

2.4 Referrals.

To the extent required by the terms of the applicable Plan, Group shall refer or admit Members only to Participating Providers for Covered Services, and shall furnish such Participating Providers with complete information on treatment procedures and diagnostic tests performed prior to such referral or admission. In addition, to the extent possible, Group shall refer Members with out of network benefits, if any, to Participating Providers. Group shall be liable for any expenses resulting from a referral to a non-Participating Provider that Company did not pre-certify in advance, as permitted by applicable law.

2.5 Group and Participating Group Provider Representations.

2.5.1 General Representations. Group represents, warrants and covenants, as applicable, that: (a) it and Participating Group Providers have, and shall maintain throughout the term of this Agreement all appropriate license(s) and certification(s) mandated by governmental regulatory agencies, which for each Participating Group Provider shall include, without limitation, DEA certification, certification to participate in the Medicaid and Medicare programs, and an unrestricted license to practice medicine in the state(s) in which such Participating Group Provider maintains offices and provides Provider Services to Members; (b) each Participating Group Provider is board certified or board eligible in the Specialty for which they provide Provider Services; (c) it and Participating Group Providers are, and will remain throughout the term of this Agreement, in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided hereunder, including, without limitation, statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, self-referral, false claims and prohibition of kickbacks; (d) each Participating Group Provider has and shall maintain throughout the term of this Agreement unrestricted hospital privileges at a Participating Hospital; (e) it is legally authorized to negotiate on behalf of Participating Group Providers and to bind those Participating Group Providers to abide by the terms of this Agreement, as amended from time to time; (f) this Agreement has been executed by its duly authorized representative; and (g) executing this Agreement and performing its obligations hereunder shall not cause Group nor Participating Group Providers to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

2.4.3 Qualified Personnel. Group also represents that Group and Participating Group Providers have established an ongoing quality assurance/assessment program which includes, but is not limited to, credentialing of employees and subcontractors. Group shall supply to Company the relevant documentation, including, but not limited to, internal quality assurance/assessment protocols, state licenses and certifications, Federal agency certifications and/or registrations upon request. Group further represents that all personnel employed by, associated or contracted with Group and Participating Group Providers who treat Members: (a) are and shall remain throughout the term of this Agreement appropriately licensed and/or certified and supervised (when and as required by state and Federal law), and qualified by education, training and experience to perform their professional duties; and (b) shall act within the scope of their licensure or certification, as the case may be. Company may

audit Group and Participating Group Providers compliance with this section upon prior written notice. Group is prohibited from using any individual or entity ("Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative or other individual or entity) to perform any services for Plans if the individual or entity is physically located outside of one of the fifty United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands.), unless Company, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity. Group further agrees that Company has the right to audit any Offshore Entity prior to the provision of services for Plans.

2.5.3 Government Program Representations. Company has or shall seek contracts to serve beneficiaries of Government Programs. To the extent Company participates in a specific Government Program, Group and Participating Group Providers agree, on behalf of themselves and any subcontractors of Group or Participating Group Providers, to be bound by all rules and regulations of, and all requirements applicable to, such Government Programs. Group and Participating Group Providers acknowledge and agree that all provisions of this Agreement shall apply equally to any employees, independent contractors and subcontractors of Group and Participating Group Providers who provide or may provide Covered Services to Members of Government Programs, and Group and Participating Group Providers represent and warrant that Group and Participating Group Providers shall cause such employees, independent contractors and subcontractors to comply with this Agreement, the State Contract, and all applicable laws, rules and regulations and perform all requirements applicable to Government Programs. Any such subcontract or delegation shall be subject to prior written approval by Company. With respect to Members of Government Programs, Group and Participating Group Providers acknowledge that compensation under this Agreement for such Members constitutes receipt of Federal funds. Group and Participating Group Providers agree that all services and other activities performed by Group and Participating Group Providers under this Agreement will be consistent and comply with the obligations of Company and/or Government Sponsor under its contract(s) with CMS, and any applicable state regulatory agency, to offer Government Programs. Group and Participating Group Providers further agree to allow Government Sponsor, CMS, any applicable state regulatory agency, and Company to monitor Group and Participating Group Providers' performance under this Agreement on an ongoing basis in accordance with applicable laws, rules and regulations. Group and Participating Group Providers acknowledge and agree that Company may only delegate its activities and responsibilities under the State Contract or any Company contract(s) with Government Sponsor, CMS and any applicable regulatory agency, to offer Government Programs in a manner consistent with applicable laws, rules and regulations, and that if any such activity or responsibility is delegated by Company to Group and Participating Group Providers, the activity or responsibility may be revoked if Government Sponsor, CMS or Company determine that Group and Participating Group Providers have not performed satisfactorily. Upon request, Group or Participating Group Provider shall immediately provide to Company any information that is required by Company to meet its reporting obligations to CMS, including without limitation, physician incentive plan information, if applicable. To the extent that Group or Participating Group Providers generates and/or compiles and provides any data to Company that Company, in turn, submits to CMS, Group and Participating Group Providers certify, to the best of their knowledge and belief, that such data is accurate, complete and truthful.

2.5.4 Suspension or Debarment. Group represents, warrants and covenants, as applicable, that it and each Participating Group Provider:

a. Has not within a three year period preceding the proposal submission been convicted or had a civil judgment rendered against him/her/it for commission of fraud or criminal offense in performing a public transaction or contract (local, state or federal) or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property; and

b. Is not presently indicted for or otherwise criminally or civilly charged by a governmental entity with the commission of any of the above offenses; and

c. Has not within a five year period preceding execution of this Agreement had one or more

public transactions terminated for cause or fault; and

d. Is not excluded, debarred or suspended from participation in any government-sponsored program including, but not limited to, Government Programs, the Medicaid program in any state or Medicare; and

e. Will immediately report any change in the above status to Company; and

f. Will maintain all appropriate licenses to perform its duties and obligations under the Agreement.

2.6 Participating Group Providers.
Notwithstanding any contrary interpretation of this Agreement or of any contracts between Group and Participating Group Providers, Group acknowledges and agrees that all provisions of this Agreement applicable to Group shall apply with equal force to Participating Group Providers, unless clearly applicable only to Group. Group agrees that it is Group's responsibility to assure that the obligations of Participating Group Providers under this Agreement are fully satisfied, that Group will take all steps necessary to cause Participating Group Providers to comply with and perform the terms and conditions of this Agreement, and that Group's failure to do so shall constitute a material breach of this Agreement by Group. Group agrees, and shall require Participating Group Providers to agree, that in the event of any inconsistency between this Agreement and any contracts entered into between Group and Participating Group Providers, the terms of this Agreement shall control. Upon request by Company, Group shall provide copies of its contracts with Participating Group Providers, if any, to Company. Group agrees that each Participating Group Provider shall execute an Individual Provider Addendum with Company in the form attached hereto.

2.7 Group Capacity.
If Company determines at any time that Members' access to Participating Group Providers is unacceptable due to any reduction in the number of Participating Group Providers, or any change in the types or geographic mix of Participating Group Providers, Company may request that Group take corrective action acceptable to Company within thirty (30) days. If Group fails to take such corrective action within such thirty (30) day period, Company may terminate this Agreement as provided in Section 6.3.

2.8 Group Providers' Information.
Group shall provide to Company a complete list of Participating Group Providers, including names, office addresses, office hours, telephone and facsimile numbers, and area of practice or specialty. Group shall notify Company in writing within ten (10) business days of its acquiring knowledge of any change in this information. Group shall provide to Company at least one hundred twenty (120) days prior notice (or, if Group does not receive at least one hundred twenty (120) days notice, then such notice as Group actually receives of the termination of Group's relationship with a Participating Group Provider. Group shall obtain a completed credentialing application to become a Participating Group Provider from each Group Provider, and shall, at Company's request, make available to Company any credentialing material held by or accessible to Group. Group shall obtain all necessary releases from Group Providers to permit Group to release said credentialing files to Company, and Company shall be entitled to presume that such releases have been obtained.

2.9 Group and Participating Group Providers' Insurance.

2.9.1 Group’s Insurance. During the term of this Agreement, Group agrees to procure and maintain such policies of general and professional liability and other insurance, or a comparable program of self-insurance, at minimum levels as required by state law or, in the absence of a state law specifying a minimum limit, an amount customarily maintained by Group in the state or region in which the Group operates. Such insurance coverage shall cover the acts and omissions of Group as well as those Group and Participating Group Providers’ agents and employees. Group agrees to deliver certificates of insurance or other documentation as appropriate to show evidence of such coverage to Company upon request. Group agrees to make best efforts to provide to Company at least thirty (30) days advance

notice, and in any event will provide notice as soon as reasonably practicable, of any cancellation or material modification of said policies.

2.9.2 Participating Group Providers' Insurance. During the term of this Agreement, each Participating Group Provider agrees to procure and maintain such policies of general and professional liability and other insurance, or a comparable program of self-insurance, at minimum levels as required by state law or, in the absence of a state law specifying a minimum limit, an amount customarily maintained by Group in the state or region in which the Group operates. Such insurance coverage shall cover the acts and omissions of Participating Group Provider as well as Participating Group Provider's agents and employees. Participating Group Provider agrees to deliver certificates of insurance or other documentation as appropriate to show evidence of such coverage to Company upon request. Participating Group Provider agrees to make best efforts to provide to Company at least thirty (30) days advance notice, and in any event will provide notice as soon as reasonably practicable, of any cancellation or material modification of said policies.

2.10 Program Participation.

Group and Participating Group Providers agree to participate in the Plans and other health benefit programs listed on the **Program Participation Schedule**. Company reserves the right to introduce and designate Group's participation in new Plans, Specialty Programs and other programs during the term of this Agreement and will provide Group with written notice of such new Plans, Specialty Programs and other programs and the associated compensation. To the extent that Company establishes and/or participates in a provider Pay-for-Performance incentive program or Performance Improvement Programs, Group agrees to comply with and participate in such program.

Nothing herein shall require that Company identify, designate or include Group and Participating Group Providers as a preferred participant in any specific Plan for which Company provides incentives based upon the use of selected Participating Providers, Specialty Program or other program; provided, however, Group and Participating Group Providers shall accept compensation in accordance with this Agreement for the provision of any Covered Services to Members under a Plan, Specialty Program or other program in which Group and Participating Group Providers have agreed to participate hereunder.

2.11 Consents to Release Medical Information.

Group and Participating Group Providers covenant that they will obtain from Members to whom Provider Services are provided, any necessary consents or authorizations to the release of Information and Records to Company, Government Sponsors, their agents and representatives in accordance with any applicable Federal or state law or regulation or this Agreement.

2.12 Encounter Data.

For those services for which Group is compensated, Group and Participating Group Providers agree to provide Company with encounter data by type of Provider Service rendered to Members in the form and manner as specified by Company. There shall be no restrictions on Company's use of such encounter data. Furthermore, Company is under no obligation to return such encounter data to Group or Participating Group Providers.

Company is or may be required to obtain encounter data from Group and Participating Group Providers for Members, and Group and Participating Group Providers agree to provide complete and accurate encounter data to Company for Members that conforms to all standards and requirements set forth in applicable laws, rules and regulations, Government Sponsor and/or CMS instructions that apply to encounter data. Group and Participating Group Providers certify, based on best knowledge, information and belief, that any encounter data that Group and Participating Group Providers submit to Company for Members is accurate, complete and truthful. Group and Participating Group Providers agree to immediately notify Company if any encounter data that was submitted to Company for Members is erroneous, and follow procedures established by Company to correct erroneous encounter data to ensure Company's compliance with applicable laws, rules and regulations, and Government Sponsor and CMS instructions.

Group and Participating Group Providers further agree to maintain accurate, legible and complete medical record documentation for all encounter data submitted to Company for Members in a format that meets all standards and requirements set forth in applicable laws, rules, regulations, and/or Government Sponsor and CMS instructions, and allows any governmental authorities with jurisdiction or their designees ("Government Officials") to, in part: (1) confirm that the appropriate diagnoses codes and level of specificity are documented ; (2) verify the date of service is documented and within the encounter data collection period; and (3) confirm that the appropriate provider's signature and credentials are present ("Medical Records").

Group and Participating Group Providers agree to provide Company and Government Officials, or their designees, with medical records and any other information or documentation required by Government Officials for the validation of encounter data ("Audit Data"). Group and Participating Group Providers agree to provide Company with Audit Data within the timeframe established by Company to ensure Company's compliance with deadlines imposed by Government Officials for the submission of Audit Data. In the event that Government Sponsor or CMS conducts a review that includes the validation of encounter data submitted by Group or Participating Group Providers, Company will submit to Group and Participating Group Providers, as applicable, a copy of the Government Sponsor or CMS written notice of such review, along with a written request from Company for Audit Data.

3.0 COMPANY OBLIGATIONS

3.1 Company's Covenants.

Company or Government Sponsors shall provide the following: a means for Members to identify themselves to Participating Group Providers (e.g., identification cards), an explanation of Group's payments, a general description of products, a listing of Participating Providers, and timely notification of Material Changes in this information. Company shall provide Group and Participating Group Providers with a means to check eligibility. Company shall include Group and Participating Group Providers in the Participating Provider directory or directories for the Plans, Specialty Programs and products in which Group and Participating Group Providers are Participating Providers, including when Group and Participating Group Providers are designated as preferred participant, and shall make said directories available to Members. Company reserves the right to determine the content of Provider directories.

3.2 Company Representations.

Company represents and warrants that: (a) this Agreement has been executed by its duly authorized representative; and (b) executing this Agreement and performing its obligations hereunder shall not cause Company to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

The parties acknowledge that one or more state governmental authorities may recommend or require that various Company agreements, including this Agreement, be executed prior to the issuance to Company of one or more approvals, consents, licenses, permissions or other authorizations from governmental authorities with jurisdiction over the subject matter of this Agreement, or which Company deems to be necessary or desirable in its sole discretion (collectively, a "License"). Group agrees that all Company obligations to perform, and all rights of Group, under this Agreement are expressly conditioned upon the receipt of all Licenses. Failure of Company to obtain any License shall impose no liability on Company under this Agreement.

3.3 Company's Insurance.

Company at its sole cost and expense agrees to procure and maintain such policies of general and/or professional liability and other insurance (or maintain a self-insurance program) as shall be necessary to insure Company and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any service by Company under this Agreement and the administration of Plans.

4.0 CLAIMS SUBMISSIONS, COMPENSATION AND MEMBER BILLING

4.1 Claim Submission and Payment.

4.1.1 Obligation to Submit Claims. Group agrees to submit Clean Claims to Company for Provider Services rendered to Members by Participating Group Providers. Group agrees to submit claim and encounter data related to a Member enrolled in a Government Program in the form and manner as specified by Company and Group certifies that any such data is accurate, complete and truthful. Group and Participating Group Providers will make best commercial efforts to submit a minimum of eighty-five percent (85%) of its Member claims electronically to Company. Group and Participating Group Providers represent that, where necessary, they have obtained signed assignments of benefits authorizing payment for Providers Services to be made directly to Group. For claims Group submits electronically, Group shall not submit a claim to Company in paper form unless Company requests paper submissions or fails to pay or otherwise respond to electronic claims submission in accordance with the time frames required under this Agreement or applicable law or regulation. Group agrees that Company, or the applicable Government Sponsor, will not be obligated to make payments for billings received more than one hundred and twenty (120) days (or such other period required by applicable state law or regulation) from (a) the date of service or, (b) the date of receipt of the primary payer's explanation of benefits when Company is the secondary payer. Company may waive this requirement if Group provides notice to Company, along with appropriate evidence, of other extraordinary circumstances outside the control of Group that resulted in the delayed submission. In addition, unless Group notifies Company of its payment disputes within one hundred eighty (180) days, or such other period as required by applicable state law or regulation, of receipt of payment from Company, such payment will be considered full and final payment for the related claims. If Group does not timely bill Company or Government Sponsors, or dispute any payment, timely as provided in this Section 4.1.1, Group's claim for payment will be deemed waived and Group will not seek payment from Government Sponsors, Company or Members. Group shall pay on a timely basis all Participating Providers, employees, independent contractors and subcontractors who render Covered Services to Members of Company's Plans for which Group is financially responsible pursuant to this Agreement.

Group agrees to permit claim editing to the primary procedure those services considered part of, incidental to, or inclusive of the primary procedure and to allow Company to make other adjustments for inappropriate billing or coding (e.g., rebundling, duplicative procedures or claim submissions, mutually exclusive procedures, gender/procedure mismatches, age/procedure mismatches). To the extent Group is billing on a CMS 1500 form, as of the Effective Date, in performing adjustments for inappropriate billing or coding, Company utilizes a commercial software package (as modified by Company for all Participating Providers in the ordinary course of Company's business) which commercial software package relies upon Government Programs and other industry standards in the development of its rebundling logic.

Subject to applicable law: (i) Company may update internal payment systems in response to additions, deletions, and changes to Government Sponsor, CMS, or other industry source codes without obtaining any consent from Group, Participating Group Providers, or any other party, and Company will provide, at the written request of Group, a copy of the fee schedule in effect at the time of such request; (ii) Company shall not be responsible for communicating such routine changes of this nature, and will update any applicable payment schedules on a prospective basis within ninety (90) days from the date of publication or such longer period as Company determines appropriate in its sole discretion; and (iii) Company shall have no obligation to retroactively adjust claims.

4.1.2 Company Obligation to Pay for Covered Services. Company shall make payments to Group for Covered Services on a timely basis consistent with the claims payment procedure described at 42 U.S.C. § 1396a(a)(37)(A). Company agrees to pay Group for non-capitated Covered Services rendered to Members according to the lesser of (i) Group's actual billed charges or (ii) the rates set forth in the **Services and Compensation Schedule**, attached hereto and made a part hereof. Company must pay ninety percent (90%) of all such Clean Claims from Group within thirty (30) days following actual receipt; provided, further, Company must pay ninety-nine percent (99%) of all Clean Claims from Group within ninety (90) days following actual receipt. Group and Participating Group Providers will make best commercial efforts to utilize online explanation of benefits or electronic remittance of advice (or combination thereof) and electronic funds transfer in lieu of receiving paper equivalents to

the extent such services are available from Company. Company reserves the right to recoup any overpayment or payment made in error (e.g., a duplicate payment or payment for services rendered by Group to a patient who was not a Member and amounts identified through routine investigative reviews of records or audits) against any other monies due to Group under this Agreement.

In the event that Group identifies any overpayments by Company, Group shall, as required under Section 6402(a) of the Patient Protection and Affordable Care Act, report and return any and all such overpayments to Company within sixty (60) days of Group's identification of any and all such overpayments. In addition, when reporting and returning any such overpayments by Company, Group must provide Company with a written reason for the overpayment (e.g., excess payment under coordination of benefits, etc.).

To the extent, if any, that the compensation under certain Plans is in the form of capitation payments or a case-based rate methodology, Group acknowledges the financial risks to Group of this arrangement and has made an independent analysis of the adequacy of this arrangement. Group, therefore, agrees and covenants not to bring any action asserting the inadequacy of these arrangements or that Group was in any way improperly induced by Company to accept the rate of payment, including, but not limited to, causes of actions for damages, rescission or termination alleging fraud or negligent misrepresentation or improper inducement. Furthermore, to the extent that the compensation under certain Plans is in the form of capitation payments or a case-based methodology and Participating Group Provider utilizes the services of a Covering Provider, Group agrees to hold Company, Government Sponsor, Affiliates, and Members harmless against any and all claims by such Covering Provider related to or arising out of payment for Covered Services rendered to Members. Group understands that if Company makes payment to such Covering Provider under the circumstances described above, Company may recoup against future payments the amount paid to such Covering Provider.

Complaints or disputes concerning payments for the provision of services as described in this Agreement shall be subject to the Company's grievance resolution system.

4.1.3 Eligibility Determinations. Company shall have the right to recover payments made to Group if the payments are for services provided to an individual who is later determined to have been ineligible based upon information that is not available to Company at the time the service is rendered or authorization is provided.

4.1.4 Group's Payment to Participating Group Providers. Group shall be financially responsible for payment to all Participating Group Providers who render Covered Services to Members. Group shall require all Participating Group Providers who render such services to look solely to Group for payment. In addition, Group shall be financially responsible for payment to any other physicians who render Covered Services to Members when Group has been compensated on a capitated basis, if any, for such services. Group shall pay on a timely basis all Participating Group Providers and other physicians who render Covered Services for which Group is financially responsible hereunder. Company shall forward any claims it receives for payment for such services to Group. Company reserves the right to pay any Participating Provider or other provider for Covered Services for which Group is financially responsible and for which a valid, undisputed invoice, or portion thereof, is outstanding for more than fourteen (14) days beyond its due date, except that Company need not wait fourteen (14) days if Group has engaged in a pattern of late payments in the past. Company may deduct any such payments from any and all amounts due and payable to Group hereunder.

4.1.5 Utilization Management. Company utilizes systems of utilization review/quality improvement/peer review to promote adherence to accepted medical treatment standards and to encourage Participating Providers to minimize unnecessary medical costs consistent with sound medical judgment and in accordance with applicable law. To further this end, Participating Group Providers agree, consistent with sound medical judgment and in accordance with applicable law:

(a) To participate, as requested, and to abide by Company's utilization review, patient management, quality improvement programs, and all other related programs (as modified from time to time) and decisions with respect to all Members.

(b) To comply with Company's pre-certification and utilization management requirements for all elective admissions and other Covered Services.

(c) To regularly interact and cooperate with Company's nurse case managers.

(d) To utilize Participating Providers to the fullest extent possible, consistent with sound medical judgment.

(e) To abide by all Company's credentialing criteria and procedures, including site visits and medical chart reviews, and to submit to these processes biannually, annually, or otherwise, when applicable.

(f) To obtain advance authorization from Company prior to any non-Emergency Service admission, and in cases where a Member requires an Emergency Service hospital admission or Post-stabilization Care Services, to notify Company, both in accordance with Company's Policies then in effect.

Except when a Member requires Emergency Services, Group and Participating Group Providers agree to comply with any applicable precertification and/or referral requirements under the Member's Plan prior to the provision of Provider Services. Group and Participating Group Providers agree to notify Company of all admissions of Members, and of all services for which Company requires notice, upon admission or prior to the provision of such services. For those Members who require services under a Specialty Program, Group and Participating Group Providers agree to work with Company in transferring the Member's care to a Specialty Program Provider.

4.2 Coordination of Benefits.

Except as otherwise required under applicable Federal, state law or regulation or a Plan, when Company or a Government Sponsor is secondary payer under applicable coordination of benefit principles, and payment from the primary payer is less than the compensation payable under this Agreement without coordination of benefits, then Company or Government Sponsor will pay Group the lesser of (i) the copayment, coinsurance and deductible amount for the Covered Services as reported on the explanation of benefits of the primary payer, or (ii) the amount of the difference between the amount paid by the primary payer and the compensation payable under this Agreement, absent other sources of payment. Notwithstanding any other provision of this paragraph, if payment from the primary payer is greater than or equal to the compensation payable under this Agreement without coordination of benefits, neither Company, Government Sponsor nor the applicable Member (in accordance with Section 4.3.2 below) shall have any obligation to Group. Notwithstanding anything to the contrary in this section, in no event shall Group collect more than Medicare allows if Medicare is the primary payer. Medicaid is never the primary payer.

4.3 Member Billing.

4.3.1 Permitted Billing of Members. Group may bill or charge Members only in the following circumstances: (a) applicable Copayments, Coinsurance and/or Deductibles, if any, not collected at the time that Covered Services are rendered; and (b) for services that are not Covered Services only if: (i) the Member's Plan provides and/or Company confirms that the specific services are not covered; (ii) the Member was advised in writing prior to the services being rendered that the specific services may not be Covered Services; and (iii) the Member agreed in writing to pay for such services after being so advised. Group acknowledges that Company's denial or adjustment of payment to Group based on Company's performance of utilization management as described in Section 4.1.4 or otherwise is not a denial of Covered Services under this Agreement or under the terms of a Plan, except if Company confirms otherwise under this Section 4.3.1. Group may bill or charge individuals who were not Members at the time that services were rendered.

4.3.2 Holding Members Harmless. Group and Participating Group Providers hereby agree that in no event, including, but not limited to the failure, denial or reduction of payment by Company, insolvency of Company or breach of this Agreement, shall Group or Participating Group Providers bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse (i) against Members or persons acting on their behalf (other than Company) or (ii) any settlement fund or other *res* controlled by or on behalf of, or for the benefit of, a Member for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance, or Deductibles made in accordance with the terms of the applicable Plan. Group and Participating Group Providers further agree that this Section 4.3.2: (a) shall survive the expiration or termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) supersedes any oral or written contrary agreement or waiver now existing or hereafter entered into between Group and Participating Group Providers and Members or persons acting on their behalf.

4.3.3 Dual Eligible Members. Group acknowledges and agrees that Members who are also enrolled in a State Medicaid plan ("Dual Eligible Members") are not responsible for paying to Group any Copayments, Coinsurance or Deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when the State Medicaid plan is responsible for paying such Cost Sharing Amounts. Group further agrees that they will not collect Cost Sharing Amounts from Dual Eligible Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the Company's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts, or, bill the applicable State source for the appropriate Cost Sharing Amounts owed by the State Medicaid plan. Dual Eligible Members in Capitated Financial Alignment Demonstration Plans are not responsible for Cost Sharing Amounts for Medicare Parts A and B services.

To protect Members, Group agrees not to seek or accept or rely upon waivers of the Member protections provided by this Section 4.3.

5.0 COMPLIANCE WITH POLICIES

5.1 Policies.

Group and Participating Group Providers agree to accept and comply with Policies of which Group knows or reasonably should have known (e.g., Clinical Policy Bulletins or other Policies made available to Group and Participating Group Providers). Group and Participating Group Providers will utilize the electronic real time HIPAA compliant transactions, including but not limited to, eligibility, precertification and claim status inquiry transactions to the extent such electronic real time features are utilized by Company. Company may at any time modify Policies. Company will provide notice by letter, newsletter, electronic mail or other media, of Material Changes. Failure by Group to object in writing to any Material Change within thirty (30) days following receipt thereof constitutes Group's acceptance of such Material Change. In the event that Group reasonably believes that a Material Change is likely to have a material adverse financial impact upon Group's practice, Group agrees to notify Company in writing, specifying the specific bases demonstrating a likely material adverse financial impact, and the Parties will negotiate in good faith an appropriate amendment, if any, to this Agreement. Notwithstanding the foregoing, at Company's discretion, Company may modify the Policies to comply with applicable law or regulation, or any order or directive of any governmental agency, without the consent of Group, and the Policies shall be deemed to be automatically amended to conform with all laws and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over this Agreement. Group and Participating Group Providers agree that noncompliance with any requirements of this Section 5.1 or any Policies will relieve Company or Government Sponsors and Members from any financial liability for the applicable portion of the Group Services.

5.2 Notices and Reporting.

To the extent neither prohibited by law nor violative of applicable privilege, Group and Participating Group Providers agree to provide notice to Company, and shall provide all information reasonably requested by Company regarding the nature, circumstances, and disposition, of: (a) any litigation or administrative action

brought against Group and Participating Group Providers or any of its employees or affiliated providers which is related to the provision of health care services and could have a material impact on the Provider Services provided to Members; (b) Company requirements regarding reporting of self-referrals, loss of licensure or accreditation, and claims by governmental agencies or individual regarding fraud, abuse, self-referral, false claims, or kickbacks; and (c) any material change in services provided by Group and Participating Group Providers or licensure status related to such services; and (d) to maintain Information and Records in accordance with the requirements of Exhibits A & D, as applicable. Company and Group agree to be mutually committed to promoting Member safety and quality. Therefore, Group will report the occurrence of and waive all charges related to those conditions specified under Section 5001(c) of the Deficit Reduction Act, Section 2702 of the Affordable Care Act and any related or similar federal or state regulation, in accordance with the terms thereof. Group agrees to use best efforts to provide Company with prior notice of, and in any event will provide notice as soon as reasonably practicable notice of, any actions taken by or against Group or Participating Group Providers described in this Section 5.2.

5.3 Information and Records.

5.3.1 Maintenance of Information and Records. Group and Participating Group Providers agree (a) to maintain Information and Records (as such terms are defined in Section 5.3.2) in a current, detailed, organized and comprehensive manner and in accordance with customary medical practice, Government Sponsor directives, applicable Federal and state laws, and accreditation standards; (b) that all Member medical records and Confidential Information shall be treated as confidential and in accordance with applicable laws; (c) to maintain such Information and Records for the longer of six (6) years after the last date Provider Services were provided to Member, or the period required by applicable law or Government Sponsor directives. This Section 5.3.1 shall survive the termination of this Agreement, regardless of the cause of the termination.

5.3.2 Access to Information and Records. Group and Participating Group Providers agree that (a) Company (including Company's authorized designee) and Government Sponsors shall have access to all data and information obtained, created or collected by Group and Participating Group Providers related to Members and necessary for payment of claims, including without limitation Confidential Information ("Information"); (b) Company (including Company's authorized designee), Government Sponsors and Federal, state, and local governmental authorities and their agents having jurisdiction, upon request, shall have access to all books, records and other papers (including, but not limited to, contracts, medical and financial records and physician incentive plan information) and information relating to this Agreement and to those services rendered by Participating Group Providers to Members ("Records"); (c) consistent with the consents and authorizations required by Section 2.12 hereof, Company or its agents or designees shall have access to medical records for the purpose of assessing quality of care, conducting medical evaluations and audits, and performing utilization management functions; (d) applicable Federal and state authorities and their agents shall have access to medical records for assessing the quality of care or investigating Member grievances or complaints; and (e) Members shall have access to their health information as required by 45 C.F.R. § 164.524 and applicable state law, be provided with an accounting of disclosures of information when and as required by 45 C.F.R. § 164.528 and applicable state law, and have the opportunity to amend or correct the information as required by 45 C.F.R. § 164.526 and applicable state law. Group and Participating Group Provider agree to supply copies of Information and Records within fourteen (14) days of the receipt of a request, where practicable, and in no event later than the date required by Government Sponsor directives and any applicable law or regulatory authority. Subject to the provisions of this section as well as other provisions of this Agreement, Company confirms that, as between Company and Group and Participating Group Providers, Group and Participating Group Providers owns Group and Participating Group Providers' medical records. This Section 5.3.2 shall survive the termination of this Agreement, regardless of the cause of termination.

5.3.3 Government Requirements Regarding Records for Medicare Members. In addition to the requirements of Sections 5.3.1 and 5.3.2, with respect to Medicare Plans, Group agrees to maintain Information and Records (as those terms are defined in Section 5.3) for the longer of: (i) ten (10) years from the end of the final contract period of any government contract of Company, (ii) the date the U.S. Department of

Health and Human Services ("HHS"), the U.S. Comptroller General, or their designees complete an audit, or (iii) the period required by applicable laws, rules or regulations. Group further agrees that, with respect to Medicare Plans, Company and Federal, state and local government authorities having jurisdiction, or their designees, upon request, shall have access to all Information and Records, and that this right of inspection, evaluation and audit of Information and Records shall continue for the longer of (i) ten (10) years from the end of the final contract period of any government contract of Company, (ii) the date HHS, the U.S. Comptroller General, or their designee complete an audit, or (iii) the period required by applicable laws, rules or regulations. This Section 5.3.3 shall survive the termination of this Agreement, regardless of the cause of termination.

5.4 Quality, Accreditation and Review Activities.
Group and Participating Group Providers agree to cooperate with any Company quality activities or review of Company or a Plan conducted by the National Committee for Quality Assurance (NCQA) or a Federal or state agency with authority over Company and/or the Plan, as applicable.

5.5 Proprietary Information.

5.5.1 Rights and Responsibilities. Each Party agrees that the Proprietary Information of the other Party is the exclusive property of such Party and that each Party has no right, title or interest in the same. Each Party agrees to keep the Proprietary Information and this Agreement strictly confidential and agrees not to disclose any Proprietary Information or the contents of this Agreement to any third party without the other Party's consent, except (i) to governmental authorities having jurisdiction, (ii) in the case of Company's disclosure to Members, Government Sponsors, consultants or vendors under contract with Company, and (iii) in the case of Participating Group Providers' disclosure to Members for the limited purpose of advising Members of potential treatment options and costs consistent with applicable Federal and state laws. Except as otherwise required under applicable Federal or state law, each Party agrees to not use any Proprietary Information of the other Party, and at the request of the other Party hereto, return any Proprietary Information upon termination of this Agreement for whatever reason. Notwithstanding the foregoing, Participating Group Providers are encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which the Group or Participating Group Providers are paid. In addition, Participating Group Providers may freely communicate with patients about their treatment options, regardless of benefit coverage limitations. This Section 5.5.1 shall survive the termination of this Agreement for one (1) year, regardless of the cause of termination.

6.0 TERM AND TERMINATION

6.1 Term.
This Agreement shall be effective for an initial term ("Initial Term") of one (1) year from the Effective Date, and thereafter shall automatically renew for additional terms of one (1) year each, unless and until terminated in accordance with this Article 6.0.

6.2 Termination without Cause.
This Agreement may be terminated by Company at any time without cause with at least ninety (90) days prior written notice to Group. This Agreement may be terminated by Group without cause at any time following the conclusion of the Initial Term with at least ninety (90) days prior written notice to Company.

6.3 Termination for Breach.
This Agreement may be terminated at any time by either Party upon at least thirty (30) days prior written notice of such termination to the other Party upon material default or substantial breach by such Party of one or more of its obligations hereunder, unless such material default or substantial breach is cured within thirty (30) days of the notice of termination; provided, however, if such material default or substantial breach is incapable of being cured within such thirty (30) day period, any termination pursuant to this Section 6.3 will be ineffective for the period reasonably necessary to cure such breach if the breaching party has taken all steps reasonably capable of being performed within such thirty (30) day period. Furthermore, Company may terminate the status of any Participating Group Provider as a Participating Provider for default or breach of

said Participating Group Provider's obligations hereunder upon at least thirty (30) days notice to said Participating Group Provider, unless such default or breach is cured within the notice period. Notwithstanding the foregoing, the effective date of such termination may be extended pursuant to Section 6.6 herein.

6.4 Immediate Termination or Suspension.
Company may immediately terminate this Agreement or, where applicable, the status of any Participating Group Provider as a Participating Provider, at Company's discretion at any time, due to any of the following events: (a) the suspension, withdrawal, expiration, revocation or non-renewal of any Federal, state or local license, certificate or other legal credential authorizing Group and/or Participating Group Providers to practice medicine; (b) a suspension or revocation of a Participating Group Provider's DEA certification or other right to prescribe controlled substances; (c) an indictment, arrest or conviction of a felony or for any criminal charge related to or in any way impairing Group's and Participating Group Provider's practice of medicine; (d) the loss or material limitation of Group's or Participating Group Provider's insurance under Section 2.9 of this Agreement; (e) the exclusion, debarment or suspension of Group and/or any Participating Group Provider from participation in any governmental sponsored program, including, but not limited to, Government Programs, Medicare or the Medicaid program in any state; (f) the listing of Group or Participating Group Providers in the HIPDB; (g) change of control of Group to an entity not acceptable to Company; (h) any false statement or material omission of Participating Group Provider in the participation application and/or confidential information forms and all other requested information, as determined by Company in its sole discretion; (i) any adverse action with respect to Participating Group Provider's hospital staff privileges; (j) a determination by Company that Group or Participating Group Provider's continued participation in provider networks could result in harm to Members; or (k) the withdrawal, expiration or termination of the State Contract. To protect the interests of patients, including Members, Group and/or Participating Group Providers will provide immediate notice to Company of any of the aforesaid events described in clauses (a) through (j), including notification of impending bankruptcy.

6.5 Obligations Following Termination.
Following the effective date of any expiration or termination of this Agreement or any Plan, Group and Participating Group Providers and Company will cooperate as provided in this Section 6.5 and in Exhibits A, B & D, as applicable. This Section 6.5 and Exhibits A & D, as applicable shall survive the termination of this Agreement, regardless of the cause of termination.

6.5.1 Upon Termination. Upon expiration or termination of this Agreement for any reason, other than termination by Company in accordance with Section 6.4 above, Group and Participating Group Providers agree to provide Provider Services at Company's discretion to: (a) any Member under a Participating Group Provider's care who, at the time of the expiration or termination is a registered bed patient at a Participating Facility until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) any Member, upon request of such Member or the applicable Plan Sponsor, for one (1) calendar year. The terms of this Agreement, including the **Services and Compensation Schedule** shall apply to all services under this Section 6.5.1.

6.5.2 Upon Insolvency or Cessation of Operations. If this Agreement terminates as a result of insolvency or cessation of operations of Company, and as to Members of HMOs that become insolvent or cease operations, then in addition to other obligations set forth in this section, Group and Participating Group Providers shall continue to provide Provider Services to: (a) all Members for the period for which premium has been paid; and (b) Members confined in an inpatient facility on the date of insolvency or other cessation of operations until medically appropriate discharge. This provision shall be construed to be for the benefit of Members. No modification of this provision shall be effective without the prior written approval of the applicable regulatory agencies.

6.5.3 Obligation to Cooperate. Upon notice of expiration or termination of this Agreement or of a Plan, Group and Participating Group Providers shall cooperate with Company and comply with Policies in the transfer of Members to other providers.

6.5.4 Obligation to Notify Members. Upon notice of termination of this Agreement or of a Plan, Company shall provide reasonable advance notice of the impending termination to Members of Plans currently under the treatment of Group and/or Participating Group Provider, or in the event of immediate termination, as soon as practicable after termination.

6.6 Obligations During Dispute Resolution Proceedings.
In the event of any dispute between the Parties in which a Party has provided notice of termination under Section 6.3 and the dispute is required to be resolved or is submitted for resolution under Article 8.0 below, the termination of this Agreement shall be stayed and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

7.0 RELATIONSHIP OF THE PARTIES

7.1 Independent Contractor Status.
The relationship between Company and Group, as well as their respective employees and agents, is that of independent contractors, and neither shall be considered an agent or representative of the other Party for any purpose, nor shall either hold itself out to be an agent or representative of the other for any purpose. Company and Group will each be solely liable for its own activities and those of its agents and employees, and neither Company nor Group will be liable in any way for the activities of the other Party or the other Party's agents or employees arising out of or in connection with: (a) any failure to perform any of the agreements, terms, covenants or conditions of this Agreement; (b) any negligent act or omission or other misconduct; (c) the failure to comply with any applicable laws, rules or regulations; or (d) any accident, injury or damage. Group and Participating Group Providers acknowledge that all Member care and related decisions are the responsibility of Participating Group Providers and that Policies do not dictate or control a Participating Group Providers' clinical decisions with respect to the care of Members. Group agrees to indemnify and hold harmless the Government Sponsor and Company from any and all claims, liabilities and third party causes of action arising out of the Participating Group Providers' provision of care to Members. Company agrees to indemnify and hold harmless the Group from any and all claims, liabilities and third party causes of action arising out of the Company's administration of health care services in connection with the Plans. This provision shall survive the expiration or termination of this Agreement, regardless of the reason for termination.

7.2 Use of Name.
Group and Participating Group Providers consent to the use of Group and Participating Group Providers' names and other identifying and descriptive material in provider directories and in other materials and marketing literature of Company in all formats, including, but not limited to, electronic media. Group and Participating Group Providers may use Company's names, logos, trademarks or service marks in marketing materials or otherwise, upon receipt of Company's prior written consent, which shall not be unreasonably withheld.

7.3 Interference with Contractual Relations.
Group and Participating Group Providers shall not engage in activities that will cause Company to lose existing or potential Members, including but not limited to: (a) advising Company customers, Government Sponsors or other entities currently under contract with Company to cancel, or not renew said contracts; (b) impeding or otherwise interfering with negotiations which Company is conducting for the provision of health benefits or Plans; or (c) using or disclosing to any third party membership lists acquired during the term of this Agreement for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Notwithstanding the foregoing, Company shall not prohibit, or otherwise restrict, Participating Group Providers from advising or advocating on behalf of a Member who is his or her patient, for the following: (i) the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; (ii) any information the Member needs in order to decide among all relevant treatment options; (iii) the risks, benefits, and consequences of treatment or nontreatment; and (iv) the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. This section shall continue to be in effect for a period of one (1) year after the expiration or termination of this Agreement.

8.0 DISPUTE RESOLUTION

8.1 Member Grievance Dispute Resolution.
Group and Participating Group Providers agree to (a) cooperate with and participate in Company's applicable appeal, grievance and external review procedures (including, but not limited to, Medicaid appeals and expedited appeals procedures), (b) provide Company with the information necessary to resolve same, and (c) abide by decisions of the applicable appeals, grievance and review committees. Company will make available to Group and Participating Group Providers information concerning the Member appeal, grievance and external review procedures at the time of entering into this Agreement.

8.2 Provider Dispute Resolution.
Company shall provide a mechanism whereby Group may raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Group shall exhaust this mechanism prior to instituting any arbitration or other permitted legal proceeding. The Parties agree that any dispute that may arise between the Parties shall not disrupt or interfere with the provision of services to Members. Discussions and negotiations held pursuant to this Section 8.2 shall be treated as inadmissible compromise and settlement negotiations for purposes of applicable rules of evidence.

8.3 Arbitration.
Any controversy or claim arising out of or relating to this Agreement including breach, termination, or validity of this Agreement, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration. The arbitration will be administered by the American Arbitration Association ("AAA") or the Judicial Arbitration and Mediation Services ("JAMS") and conducted by a sole Arbitrator. If a party believes that the arbitrator has committed an error of law or legal reasoning, the party can appeal to a court of competent jurisdiction to correct any such error of law or legal reasoning. Depositions for discovery purposes shall not be permitted. The arbitrator may award only monetary damages in accordance with this Agreement.

8.4 Arbitration Solely Between Parties; No Consolidation or Class Action.
Any arbitration or other proceeding related to a dispute arising under this Agreement shall be conducted solely between them. Neither Party shall request, nor consent to any request, that their dispute be joined or consolidated for any purpose, including without limitation any class action or similar procedural device, with any other proceeding between such Party and any third party.

9.0 MISCELLANEOUS

9.1 Amendments.
This Agreement constitutes the entire understanding of the Parties hereto and no changes, amendments or alterations shall be effective unless signed by both Parties, except as expressly provided herein. Company may amend this Agreement upon thirty (30) days prior written notice, by letter, newsletter, electronic mail or other media (an "Amendment"). Failure by Group to object in writing to any such Amendment within thirty (30) days following receipt thereof constitutes Group's acceptance of such Amendment. In the event that Group reasonably believes that an Amendment is likely to have a material adverse impact upon Group, Group agrees to notify Company in writing, specifying the specific bases demonstrating a likely material adverse impact, and the Parties will negotiate in good faith an appropriate revised Amendment, if any, to this Agreement. Notwithstanding the foregoing, at Company's discretion, Company may amend this Agreement to comply with applicable law or regulation, or any order or directive of any governmental agency, without the consent of Group, and this Agreement shall be deemed to be automatically amended to conform with all laws and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over this Agreement. Group and Participating Group Providers agree that noncompliance with any requirements of this Section 9.1 will relieve Company or Government Sponsors and Members from any financial liability for the applicable portion of the Provider Services. Changes to Policies are addressed by Section 5.1 hereto.

9.2 Waiver.
The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, all waivers must be in writing and signed by an authorized officer of the Party to be charged. Group waives any claims or cause of action for fraud in the inducement or execution related hereto.

9.3 Governing Law.
This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State of Iowa.

9.4 Liability.
Notwithstanding Section 9.3, either Party's liability, if any, for damages to the other Party for any cause whatsoever arising out of or related to this Agreement, and regardless of the form of the action, shall be limited to the damaged Party's actual damages. Neither Party shall be liable for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whatsoever sustained as a result of a breach of this Agreement or any action, inaction, alleged tortious conduct, or delay by the other Party.

9.5 Severability.
Any determination that any provision of this Agreement or any application thereof is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Neither Party shall assert or claim that this Agreement or any provision hereof is void or voidable if such Party performs under this Agreement without prompt and timely written objection.

9.6 Successors; Assignment.
This Agreement relates solely to the provision of Provider Services by Group and Participating Group Providers and does not apply to any other organization which succeeds to Group assets, by merger, acquisition or otherwise, or is an affiliate of Group. Neither Party may assign its rights or its duties and obligations under this Agreement without the prior written consent of the other Party, which consent may not be unreasonably withheld; provided, however, that Company may assign its rights or its duties and obligations to an Affiliate or successor in interest so long as any such assignment or delegation will not have a material impact upon the rights, duties and obligations of Group.

9.7 Headings.
The headings contained in this Agreement are included for purposes of convenience only, and shall not affect in any way the meaning or interpretation of any of the terms or provisions of this Agreement.

9.8 Notices.
Except for any notice required under Article 6, Term and Termination, or if otherwise specified, notices required pursuant to the terms and provisions hereof may be effective if sent by letter, electronic mail or other generally accepted media. With respect to notices required under Article 6, notice shall be effective only if given in writing and sent by overnight delivery service with proof of receipt, or by certified mail return receipt requested. Notices shall be sent to the addresses set forth on the signature page of this Agreement (which addresses may be changed by giving notice in conformity with this Section 9.8). Provider shall notify Company of any changes in the information provided by Provider related to Provider's address.

9.9 Remedies.
Notwithstanding Sections 8.3 and 9.4, the Parties agree that each has the right to seek any and all remedies at law or equity in the event of breach or threatened breach of Section(s) 5.5, 6.6 and 7.3.

9.10 Force Majeure.
If either Party shall be delayed or interrupted in the performance or completion of its obligations hereunder by any act, neglect or default of the other Party, or by an embargo, war, act of terror, riot, incendiary, fire, flood, earthquake, epidemic or other calamity, act of God or of the public enemy, governmental act (including, but not restricted to, any government priority, preference, requisition, allocation, interference, restraint or seizure, or the necessity of complying with any governmental order, directive, ruling or request)

then the time of completion specified herein shall be extended for a period equivalent to the time lost as a result thereof. This Section 9.10 shall not apply to either Party's obligations to pay any amounts owing to the other Party, nor to any strike or labor dispute involving such Party or the other Party.

9.11 Non-Exclusivity.
This Agreement is not exclusive, and nothing herein shall preclude either Party from contracting with any other person or entity for any purpose. Company makes no representation or guarantee as to the number of Members who may select or be assigned to Group and Participating Group Providers.

9.12 Confidentiality**.**
It is further understood and agreed by and among the Parties that the terms and conditions of this Agreement, except as otherwise specified, are and shall remain confidential, and shall not be disclosed by either Party without express written consent of the other Party or as required by law or by governmental authorities or by express order by a court having jurisdiction over the Party from whom disclosure is sought.

9.13 Entire Agreement.
This Agreement (including any attached schedules, appendices and/or addenda) constitutes the complete and sole contract between the Parties regarding the subject matter described above and supersedes any and all prior or contemporaneous oral or written representations, communications, proposals or agreements not expressly included in this Agreement and may not be contradicted or varied by evidence of prior, contemporaneous or subsequent oral representations, communications, proposals, agreements, prior course of dealings or discussions of the Parties. The Parties understand and agree that this Agreement only applies to the Plans described in this Agreement and, likewise, this Agreement does not and will not supersede any agreement(s) between Company's affiliates and Provider that relates to Company's affiliates other lines of business that are not the subject of this Agreement (that are not the Plans described in this Agreement).

9.14 Signatures. Facsimile and electronic signatures shall be deemed to be original signatures for all purposes of this Agreement.

9.15 Incorporation of Recitals. The Parties incorporate the recitals into this Agreement as representations of fact to each other.

Remainder of page intentionally left blank. Signature page follows.

IN WITNESS WHEREOF, the undersigned parties have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.

Group Sign Here

GROUP	**COMPANY**
By:_____	By:_____
Printed Name:_____	Printed Name:_____
Title:_____	Title:_____
Date:_____	Date:_____

REIMBURSEMENT ADDRESS:

_____
_____
_____

MAIN TELEPHONE NUMBER:_____

CHIEF EXECUTIVE OFFICER:_____

CHIEF FINANCIAL OFFICER:_____

BUSINESS OFFICE MANAGER:_____

FEDERAL TAX I.D. NUMBER:_____

NPI NUMBER:_____

As required by Section 9.8 ("Notices") of this Agreement, notices shall be sent to each Party at the following addresses:

To Group at:
_____
_____
_____
_____
_____

To Company at:

Aetna Better Health of Iowa
4320 NW 114th Street
Urbandale, IA 50322

With a copy to:
Aetna
Law Dept, Medicaid, Mail Code RE6A
151 Farmington Avenue
Hartford, CT 06156-0001

PROGRAM PARTICIPATION SCHEDULE

Group agrees to participate in the Plans and other health benefit programs listed herein upon issuance of any required licenses and contracts to Company:

Iowa Medicaid managed care Plans offered by Aetna Better Health of Iowa Inc., pursuant to contract with the Iowa Department of Human Services for delivery of high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa hawk-i programs.

SERVICES AND COMPENSATION SCHEDULE

1.0 COMPENSATION

Iowa Medicaid, CHIP & QHP Plans:	Aetna Medicaid Market Fee Schedule
Iowa Medicare Plans:	Medicare Allowable Rate

2.0 SERVICES

Provider will be reimbursed for those Covered Services in accordance with the terms of this Agreement that are within the scope of and appropriate to the Provider's license and certification to practice.

3.0 GENERAL COMPENSATION TERMS AND CONDITIONS

Definitions

"Aetna Medicaid Market Fee Schedule (AMMFS)" – A fee schedule that is based upon the contracted location where service is performed and the State of Iowa's Medicaid Fee Schedule.

"Medicare Allowable" - the current payment as of discharge date that a hospital will receive from Company, subject to the then current Medicare Inpatient Prospective Payments Systems and will be updated in accordance with CMS changes, provided, however, that exempt units for psychiatric, rehabilitation and skilled nursing facility services will be paid in accordance with the applicable Medicare Prospective Payment Systems. These payments are intended to mirror the payment a Medicare Fiscal Intermediary ("FI") would make to the hospital, less (with respect to DRG-based payments) the payments for Indirect Medical Education (IME), Direct Graduate Medical Education (DGME), bad debt, as appropriate and adjusted by CMS or Government Sponsor for sequestration, SGR or other items and Aetna payment and processing guidelines. For other provider types, the Medicare allowable rate is based upon CMS Geographic Pricing Cost Indices (GPCI) and Resource Based Relative Value Scale (RBRVS) Relative Value Units (RVU) including Outpatient Prospective Payment System (OPPS) cap rates; the Clinical Laboratory Fee Schedule (CLAB); the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule; including PEN (DMEPOS) and 'Medicare Part B Drug Average Sales Price (ASP),' as appropriate. Coding and fees determined under this schedule will be updated as CMS releases code updates, changes in the MFS relative values, including OPPS cap payments, or the CMS conversion factors. Company plans to update the schedule within 90 days of the final rates and/or codes being published by CMS. However, the rates and coding sets for these services do not become effective until updates are completed by Company and payment is considered final and exclusive of any retroactive or retrospective CMS adjustments to the rate. Company payment policies apply to services paid based upon the Medicare allowable rate.

General

A. Member Cost Share. Rates are inclusive of any applicable Member Copayment, Coinsurance or Deductible.

B. Billing. When billing, Provider must designate applicable codes related to those Covered Services provided by Provider under the terms of this Agreement.

C. Coding. Company utilizes nationally recognized coding structures including, but not limited to, Revenue Codes as described by the Uniform Billing Code, AMA Current Procedural Terminology (CPT4), CMS Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), ICD-9 (or successor standard) Diagnosis and Procedure codes or successor standard, and National Drug Codes (NDC). As changes are made to nationally-recognized codes, Company will update internal systems to accommodate new codes. Such changes will only be made when there is no material change in the procedure itself. Until updates are complete, the procedure will be paid according to the standards and coding set for the prior period.

The use of ICD-10 coding shall not impact the aggregate rates and compensation intended by the Parties as set forth in this Services and Compensation Schedule. Consequently, in the event that use of ICD-10 codes result in aggregate payments that would differ from the aggregate payments that would have resulted based on ICD-9 coding (excluding utilization and validated case mix severity changes), the rates set forth in this Services and Compensation Schedule will be reviewed by Company periodically and adjusted at least annually in order to reflect what would have been paid had ICD-9 coding been utilized for determination of the payments.

Company will comply and utilize nationally recognized coding structures as directed under applicable Federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act (HIPAA).

D. Affordable Care Act Primary Care Enhancement. For those primary care Covered Services that the State of Iowa has determined to reimburse at 100% of the Medicare allowable amount in accordance with Section 1902(a)(13)(C) of the Social Security Act, for so long as the rates are in effect and so long as Provider Group meets the requirements of applicable law for the rates, Company shall compensate Provider for the provision of such Covered Services to eligible Members delivered in accordance with the terms and conditions set forth in this Agreement at the lesser of Hosptial's billed charges or an amount equal to but not greater than the State's enhanced rates. Provider certifies that, to the extent required by law, such payments will insure to the benefit of the individual Participating Physicians, and will supply Company with any legally-required documentation of such. Company reserves the right i) to pay such enhanced compensation through monthly or quarterly adjustment; ii) to make payments directly to qualifying Participating Physicians; and/or iii) to require such Physicians or Hospital to complete any agreements, forms, attestations or releases needed to effectuate such payments. Enhanced compensation is not available for Members of CHIP Plans.

E. Medicare-Medicaid Dual-Eligibles – Where Company is the responsible payor for Medicare and Medicaid Covered Services, rates for each service are determined by whether that service is regarded as a Medicare Covered Service or a Medicaid Covered Service by CMS and Government Sponsor, and with respect to a Member's benefit limits under each program. For Medicare Covered Services (inclusive of Member Copayment or Coinsurance), Company shall compensate provider at the specified Medicare rate. For Medicaid Covered Services, Company shall compensate provider according to the applicable Medicaid rate. When a service is covered under Medicare and Medicaid, Company will determine the rate (Medicare or Medicaid) according to applicable law, coordination of benefit principles and the terms of Member's Plan. Rates do not include, and Company is not responsible for, supplemental or wrap-around payments unless required by Company's contracts with Government Sponsor.

INDIVIDUAL PROVIDER ADDENDUM

The undersigned provider ("Provider"), an employee, partner, shareholder or contractor of [_____] ("Group"), acknowledges and represents that Group is his/her attorney-in-fact for the purposes of negotiating, consenting to and executing the Provider Group Agreement (the "Agreement"), between Company and Group and any documents related to amendments to the Agreement. Terms capitalized herein but not otherwise defined shall have the meanings ascribed to them in the Agreement.

Provider hereby acknowledges that Provider has had the opportunity to review the Agreement, under which Group, on behalf of Provider, agrees to participate in Company's provider networks and provide Covered Services to Members enrolled in the Plans. Provider hereby agrees to be bound by the terms and conditions of the Agreement, including, without limitation, compliance with the participation criteria set forth in the **Participation Criteria Schedule** as applicable to Provider and all applicable Company Policies.

Provider hereby agrees that in the event: (i) Provider ceases to be a member of Group; (ii) the Agreement expires or is terminated for any reason; (iii) Group is dissolved; (iv) a voluntary or involuntary bankruptcy or a proposed settlement of outstanding debts under applicable reorganization or insolvency laws is filed by or against Group, a receiver is appointed or Group makes an assignment for the benefit of creditors; or (v) Group otherwise ceases to exist, either voluntarily or involuntarily, the terms of the Agreement shall, at Company's option, survive with respect to Provider for the first six (6) months after such event ("Continuation Period"), in which case Provider shall continue to provide services to Members in accordance with the terms of the Agreement during the Continuation Period and compensation during the Continuation Period shall be at the rate set forth in the Agreement.

With the exception of services provided to Members during the Continuation Period (when Provider will bill Company directly), Provider hereby agrees to seek compensation solely from Group for services rendered to Members under the terms of the Agreement, and shall in no event bill Company, Government Sponsor or Members for any such services (except for any Copayments, Coinsurance or Deductibles, if any, that Members may be required to pay for certain Covered Services). Provider further agrees that in no event, including but not limited to non-payment by Company, insolvency of the Company or breach by Company of the Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member or persons acting on Member's behalf for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance or Deductibles, if any, as set forth in the Agreement. Provider further agrees that this provision shall be construed for the benefit of Members, shall supersede any oral or written agreement to the contrary now existing or hereafter entered into between Provider or Group and a Member or any person acting on behalf of a Member, and shall survive the termination of the Agreement, regardless of the cause giving rise to termination.

Company, Group and Provider desire to promote continuity of care. Accordingly, upon expiration or termination of the Continuation Period for any reason, Provider agrees to provide Provider Services pursuant to the terms of the Agreement, including the compensation terms, at Company's discretion to: (a) any Member under a Provider's care who, at the time of the expiration or termination is a registered bed patient at a Participating Facility until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) any Member, upon request of such Member or the applicable Government Sponsor for one (1) calendar year.

In the event Group is dissolved or otherwise ceases to exist, Provider shall be bound by the terms of this Individual Provider Addendum, and shall be compensated for Covered Services according to the terms and conditions set forth in the Agreement.

IN WITNESS WHEREOF, the undersigned has executed this Individual Provider Addendum as of this ___ day of _____, 20 __, intending to be legally bound hereby.

PROVIDER:_____
PRINTED NAME:_____
NPI NUMBER: _____

Exhibit A

Iowa Regulatory Compliance Addendum

This Regulatory Compliance Addendum is incorporated by reference into the Agreement. It applies to Iowa Medicaid managed care plans offered by Better Health of Iowa Inc. ("Company"), pursuant to contract with the Iowa Department of Human Services (DHS) for delivery of high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa hawk-i programs and the eligible populations covered by the State Contract between Company and DHS. This Addendum is effective as of the Effective Date of the Agreement.

Provider agrees that all applicable terms and conditions set out in the RFP, the State Contract, any incorporated documents and all applicable state and federal laws, as amended, govern the duties and responsibilities of the Provider with regard to the provision of services to members in the programs applicable hereto. The RFP and State Contract may currently be found at: http://bidopportunities.iowa.gov/?pgname=viewrfp&rfp_id=11140

If there is any conflict between the terms of this Addendum and any of the other terms of the Agreement, including any attachments, schedules, exhibits and/or addenda made part of the Agreement, the terms of this Addendum will govern and control; provided, however, if there is any conflict between any of the terms of the Agreement, including this Addendum, and the State Contract, then the terms of the State Contract will govern and control. For purposes of this Regulatory Compliance Addendum, the term "Provider" shall mean the health care physician, provider, group, facility or hospital executing the Agreement, as identified on the first page of the Agreement.

1.0 DEFINITIONS [taken from the RFP Glossary]

When used in this Agreement, all capitalized terms shall have the following meanings:

Children's Health Insurance Program ("CHIP"). The program created in 1997 by Title XXI of the Social Security Act and known in Iowa as CHIP.

Claim. A formal request for payment for benefits received or services rendered.

CMS. The Centers for Medicare and Medicaid Services.

Co-Payment. A cost-sharing arrangement in which a Member pays a specified charge for a specified service; also called a co-pay.

Covered Services. Those health care services/benefits to which an individual eligible for Medicaid/CHIP is entitled under the Iowa Medicaid State Plan and which Company is required to provide or arrange for pursuant to the State Contract.

IDPH. Iowa Department of Public Health.

IDPH Participants. A resident of the State of Iowa with an income at or below 200% of the federal poverty guidelines as published by the Department of Health and Human Services who is not insured or for whom third party payment is not available to pay for services. An Iowa Medicaid member shall not be an IDPH Participant. An Iowa Health and Wellness Plan member may be an IDPH Participant for those IDPH-funded substance use disorder services that are not fully covered by the Iowa Health and Wellness Plan.

Iowa Department of Human Services ("DHS"). The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Iowa.

Iowa Medicaid State Plan. The binding written agreement between DHS and CMS, which describes how the Medicaid program is administered and determines the services for which DHS will receive federal financial participation.

Medicaid. A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act Amendment. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving covered individuals.

Medical Records. All medical, behavioral health, and long-term care histories; records, reports and summaries; diagnoses; prognoses; record of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, behavioral health, and long-term care documentation in written or electronic format; and analyses of such information.

Medically Necessary Services. Those Covered Services that are, under the terms and conditions of the State Contract, determined through Company utilization management to be:

(1) Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the Member;

(2) Provided for the diagnosis or direct care and treatment of the condition of the Member enabling the Member to make reasonable progress in treatment;

(3) Within standards of professional practice and given at the appropriate time and in the appropriate setting;

(4) Not primarily for the convenience of the Member, the Member's physician or other provider; and

(5) The most appropriate level of Covered Services, which can safely be provided.

Member. A Medicaid recipient who is subject to mandatory enrollment or is currently enrolled in Company's coverage under the State Contract.

Policies. In addition to the policies and procedures promulgated by Company, which relate to the duties and obligations of the Parties under the terms of the Agreement, Policies include the general principles by which DHS is guided in its management of the Title XIX program, as further set forth and defined by DHS promulgations and by state and federal rules and regulations.

Provider Preventable Conditions. Situations in which Medicaid payment is prohibited for services that should have been avoidable as defined in 42 CFR §447.26.

State Contract. The written agreement between Company and DHS, a copy of which may be found by Provider on the State's website. The State Contract is comprised of and incorporates all provisions of the RFP and any addenda, appendices, attachments or amendments thereto, as well as any Member handbook, provider handbook and/or other applicable policy guides, manuals and materials.

2.0 PROVIDER SERVICES AND OBLIGATIONS

2.1 Medical Necessity.
Provider agrees that for the purposes of Covered Services to Members, "Medically Necessary Services" shall be as defined above in this Addendum.

2.2 Timely Access.
Provider must meet the standards for timely access to care and services for Members as set forth on Exhibit B to the RFP, taking into account the urgency of the need for services. Provider must offer hours of operation to Members that are no less than the hours of operation offered to other non-Medicaid patients, or if Provider serves only Medicaid beneficiaries, hours of operation comparable to the hours of operation offered to enrollees of any Iowa Medicaid Fee for Service Program. Provider agrees to provide Covered Services to Members on a twenty-four (24) hour per day, seven (7) day per week basis. [42 CFR 438.209]

2.3 Inability To Pay Co-Payment.

Provider shall not deny care or services to any Member because of the Member's inability to pay the Co-Payment. [RFP SOW §5.3.5]

2.4 Medical Records.

Provider shall create and maintain Medical Records for Members in accordance with applicable law including, but not limited to, Iowa Administrative Code Title 441, Chapter 79.3 and Policies. Without limiting the foregoing, Provider's records must be maintained in a manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical Records must be legible, signed, dated and maintained as required by law. Provider shall provide a copy of the Member's Medical Record to the Member upon reasonable request by the Member at no charge. Provider shall facilitate the transfer of a Member's Medical Record to another provider at the Member's request. Provider must maintain the confidentiality of and access to Medical Records in accordance with the standards mandated in the Health Insurance Portability and Accountability Act and all other state and federal requirements. Provider shall permit Company, representatives of DHS, and other authorized entities to review Members' Medical Records for purpose of monitoring Provider's compliance with the record standards, capturing information for clinical studies, monitoring quality or any other reason. Without limiting the foregoing, Provider will release mental health information regarding Members only as allowed by Iowa Code §228. [RFP SOW §6.1.9 & 2.15]

2.5 Member Rights.

Provider shall take Members' rights as set forth in law into account when providing services to Members. Such rights include the right to receive information as set forth in 42 CFR §438.100, the right to be treated with respect and with due consideration for his or her dignity and privacy; the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand; the right to participate in decisions regarding his or her health care, including the right to refuse treatment; the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion; the right to treatment in the least restrictive setting; the right to fully participate in the community and to work, live and learn to the fullest extent possible; and the right to be furnished health care services in accordance with 42 CFR §§438.206 through 438.210. [RFP SOW §1.4.1]

2.6 Critical Incidents.

If Provider is a provider who has personal contact with Members under the Home-and-Community-Based Services (HCBS) habilitation and waiver services, Provider shall (i) report critical incidents; (ii) respond to critical incidents; (iii) document critical incidents; and (iv) cooperate with any investigation conducted by Company or an outside agency. Provider shall complete any critical incident training required by Company. [RFP SOW §10.4.2]

2.7 Enforcement of §6032 of the 2005 Deficit Reduction Act (DRA).

If Provider receives five million dollars ($5,000,000) or more in Medicaid payments in a federal fiscal year, Provider shall have written policies for all employees, including management, and for all employees of any contractor or agent, that provide detailed information about the following: [RFP SOW §12.12]

a. The Federal False Claims Act under title 31 of the United States Code, sections 3729 through 3733;

b. Administrative remedies for false claims and statements under title 31 of the United States Code, chapter 38;

c. Any State laws pertaining to civil or criminal penalties for false claims and statements (Iowa Code 249A.8 and 714.8(10)-714.14);

d. Whistleblower protections under such laws; and

e. The Provider's policies and procedures for detecting and preventing fraud, waste, and abuse.

2.8 Additional Duties For Nursing Facilities. If Provider is a nursing facility, Provider shall: [RFP SOW §6.1.2.1]

a. Promptly notify Company of a Member's admission or request for admission to the nursing facility as soon as the facility has knowledge of such admission or equest for admission;

b. Notify the Company immediately if the nursing facility is considering discharging a Member and to consult with the Member's care coordinator;

c. Notify the Member and/or the Member's representative (if applicable) in writing prior to discharge in accordance with state and federal requirements;

d. Collect from any Member the Member's patient liability amount as communicated to Provider by Company. Provider agrees that payments from Company to Provider will be net of the applicable patient liability amount for any Member with patient liability.

e. Notify Company of any change in a Member's medical or functional condition that could impact the Member's level of care eligibility for the currently authorized level of nursing facility services;

f. Comply with federal Preadmission Screening and Resident Review ("PASRR") requirements to provide or arrange to provide specialized services and all applicable Iowa law governing admission, transfer and discharge policies; and

g. hereby agrees that the Agreement will automatically be terminated in accordance with federal requirements if Provider is involuntarily decertified by the State or CMS.

2.9 Additional Duties for Home and Community-Based Services. If Provider provides Home and Community-Based Services, Provider shall: [RFP SOW §6.1.2.2]

a. Provide at least thirty (30) days advance notice to the Company when the Provider is no longer willing or able to provide services to a Member and to cooperate with the Member's care coordinator to facilitate a seamless transition to alternate providers;

b. In the event that a HCBS provider change is initiated for a Member, regardless of any other provision in Agreement, continue to provide services to the Member in accordance with the Member's plan of care until the Member has been transitioned to a new provider, as determined by the Company, or as otherwise directed by the Company, which may exceed thirty (30) days from the date of notice to the Company;

c. Immediately report any deviations from a Member's service schedule to the Member's care coordinator;

d. Comply with the critical incident reporting requirements.

e. Comply with all child and dependent adult abuse reporting requirements.

2.10 Additional Duties for Community-Based Services Providers For Resident Transfer and Discharge. Neither Company nor Provider shall transition nursing facility, ICF/ID, 1915(i) Habilitation or 1915(c) community-based residential alternative residents to another facility or residence unless: (i) the Member or

his/her representative specifically requests to transition; (ii) the Member or his/her representative provides written consent to transition based on quality or other concerns raised by the Company or Provider, which shall not include the residential provider's rate of reimbursement; or (iii) the provider has chosen not to contract with the Company. The Company shall establish contractual terms with its providers, subject to approval by DHS, that protects an individual from involuntary discharge that may lead to a placement in an inappropriate or more restrictive setting. The Company shall facilitate a seamless transition whenever a Member transitions between facilities or residences. [RFP SOW §4.3.10]

2.11 Additional Duties for Providers with IDPH Participants.
If Provider provides services to IPDH Participants who are intravenous ("IV") drug users, Provider shall perform outreach activities. Provider shall select, train and supervise outreach workers. Provider shall encourage individuals needing IV treatment to undergo treatment and provide awareness about the relationship between IV drug use and communicable disease. Provider shall use outreach models that are applicable to the local situation and use an approach that can be expected to be reasonably effective. [RFP SOW §3.2.8.15]

2.12 Additional Duties for IHH Providers.
If Provider provides integrated health homes services, Provider agrees to provide the following: (i) quality-driven, cost-effective, culturally appropriate, and person-and family-driven health home services; (ii) high-quality health care services informed by evidence-based clinical practice guidelines; (iii) preventive and health promotion services informed by evidence-based clinical practice guidelines; (iv) preventive and health promotion services, including prevention of mental illness and substance use disorders; (v) comprehensive care management, care coordination and transitional care across settings; (vi) chronic disease management, including self-management support to Members and their families; (vii) demonstrating a capacity to use health information technology to link services, facilitate communication among team members and between the health home team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and (viii) establishing a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level. [RFP SOW §3.2.9.1.2]

3.0 CLAIMS SUBMISSION, COMPENSATION AND MEMBER BILLING

3.1 Timely Filing.
Provider shall submit all Claims that do not involve a third party payer, to Company within ninety (90) days of the date of service. [RFP SOW §6.1.2]

3.2 Cost Sharing and Patient Liability.
Provider shall not require any cost sharing or patient liability responsibilities for Covered Services except to the extent that cost sharing or patient liabilities are required for those services in accordance with law and the Agreement. [RFP SOW §3.2.15.3]

3.3 Third Party Liability.
Provider shall identify any third party liability coverage available to a Member, including Medicare and long-term care insurance, as applicable, and except as otherwise required, seek such third party liability payment before submitting Claims to Company. [RFP SOW §6.1.2]

3.4 Payment Net of Co-Payment.
Provider acknowledges and agrees that Company shall reduce the amount of payment it makes to Provider by the amount of the Member's Co-Payment obligation regardless of whether Provider has collected or waived the Co-Payment, except as provided in 42 C.F.R. §447.56(c). [RFP SOW §5.3.6]

3.5 Missed Appointments.
Provider shall not charge Members for missed appointments. [RFP SOW §3.2.15.3]

3.6 IDPH Participant Substance Use Disorder Services.

If and to the extent Provider provides substance use disorder services to IDPH Participants, Provider agrees to accept payment from the IDPH Participant according to the IDPH-approved siding fee schedule for such substance use disorder services. Providers billing and collection procedures for IDPH Participants shall be consistent with those established and provided by the IDPH. Provider agrees that services funded partially or completely by IDPH shall not be denied to a person because of the inability of the person or group to pay a fee for the service. Further, Provider shall not charge and IDPH Participant for missed appointments; provided, however, that Provider may charge the IDPH Participant a one-time no-show fee in an amount not to exceed that established by the IDPH. Provider acknowledges and agrees that IDPH funds are the payment of last resort for substance use disorder services provided to IDPH Participants and shall comply with IDPH and Company policies on IDPH eligibility for person with insurance coverage. [RFP SOW §5.5 & 13.6.4]

3.7 Provider Preventable Conditions.

Provider acknowledges and agrees that Company shall not make payment to Provider for a Provider Preventable Condition. This includes health-acquired conditions as identified by Medicare other than deep vein thrombosis and pulmonary embolism following total knee replacement or hip replacement surgery in pediatric and obstetric patients. Company shall also not make payment for wrong surgical or other invasive procedure on a patient or surgical, other invasive procedure performed on the wrong body part or wrong patient or any future additional to the list of non-reimbursable Provider Preventable Conditions. As a condition of payment under the Agreement, Provider agrees to comply with the reporting requirements for Provider Preventable Conditions found at 42 CFR §447.26(d). [RFP SOW §10.5]

4.0 GENERAL PROVISIONS

4.1 Debarred Individuals.

Provider represents and warrants that Provider is not and at no time has been (i) a person debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or (ii) an affiliate, as defined in the Federal Acquisition Regulation, of a person described in subsection (i) above. Provider shall immediately notify Company if at any time this representation and warranty is no longer accurate. [RFP SOW §2.6]

Exhibit D

Medicare Compliance Addendum

Without limiting any obligation of Provider under the Agreement, Provider agrees to the requirements set forth in this Addendum. Capitalized terms not otherwise defined herein, including within Schedule 1 attached hereto, shall have the meanings ascribed to them in the Agreement.

1. DESCRIPTION. This Addendum includes any Medicare plan(s) offered by Company to Medicare beneficiaries under a contract with the Centers for Medicare and Medicaid Services pursuant to Part C of Title XVIII of the Social Security Act ("Medicare Plans"). The Medicare Plans included in this Addendum do NOT include any Medicare Advantage plan(s) that the Company has deemed to be Medicare High Performance Network plans. From time to time Company and/or Payers may designate only certain Participating Providers to take part in the provider delivery network for a particular Product benefit plan(s).

2. PAYMENT.
A. In consideration of Provider's agreement to perform Covered Services in accordance with the Agreement, Provider shall be paid for Covered Services performed according to the terms of the applicable Service and Rate Schedule.

B. Company shall not pay any amounts beyond the amounts set forth in the applicable Service & Rate Schedule, including but not limited to any incentive payments that may be payable under traditional Medicare, except as expressly required by the Agreement or applicable law. Further, the Parties acknowledge and agree that payments under the Medicare program to providers, suppliers, and Medicare Advantage organizations may be adjusted as the result of legislation, regulation, executive order or other federal mandate ("Medicare Payment Adjustment"). Furthermore, any such Medicare Payment Adjustment could result in an increase or decrease in Medicare payments. In accordance with the terms of this Agreement, the Parties agree that, in the event of a Medicare Payment Adjustment, Company's payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. Company shall adjust payments under this Agreement for Covered Services rendered by Provider on and after the effective date of the Medicare Payment Adjustment, and shall continue to adjustment payments to Provider for until the earlier of (i) the Medicare Payment Adjustment is discontinued or (ii) is replaced by a subsequent Medicare Payment Adjustment.

C. Pursuant to Section 6.K. of this Addendum, Provider certifies that the diagnosis codes submitted to Company for Medicare Members that Company is required to submit to CMS will be accurate, complete and truthful ("Certification"). Provider acknowledges and agrees that Company may impose a penalty on Provider not to exceed five thousand dollars ($5,000) for each instance that Provider submits a diagnosis code to Company for a Medicare Member that does not comply with this Certification because the diagnosis code was not submitted in the format described in 42 C.F.R. § 422.310 or any subsequent or additional federal regulations. For purposes of this Section 2, "diagnosis code" shall mean an International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) code or its successor.

D. Federal laws and regulations limit the timeframe within which CMS may recover overpayments made to physicians, providers, and suppliers who submit claims to Medicare contractors (such as fiscal intermediaries, regional home health intermediaries, carriers, Medicare Administrative Contractors, and Durable Medical Equipment Medicare Administrative Contractors) for services provided or supplied to Medicare beneficiaries enrolled in Original Medicare ("Medicare Statute of Limitations"). If Company makes an overpayment or payment in error to Provider for Medicare Members, Company shall have the right to initiate overpayment recovery efforts within the same timeframe available to CMS under the Medicare Statute of Limitations; provided that no time limit shall apply to initiation of overpayment recovery efforts based on Company's reasonable suspicion of fraud or other intentional misconduct.

3. ASSIGNMENT. In addition to all other rights of Company under the Agreement, the Agreement (including, but not limited to, as it relates to the line(s) of business described in this Addendum) may be assigned by Company, at any time and from time to time, in whole or in part, to any other affiliate or successor in interest. At Company's option, the Agreement shall survive, without any other change in its terms, as a distinct, separate agreement with

Company for those products/lines of business designated by Company and in duplicate form as a separate, distinct participating provider agreement with the applicable affiliate(s)/successor(s) for the products/lines of business assigned to such entity(ies). In the event of any assignment under this paragraph, Company shall provide advance written notice to Provider. In the event of a conflict between this paragraph and any other provision of the Agreement, the terms of this paragraph shall supersede and prevail.

4. EFFECT OF TERMINATION. In the event this Addendum is terminated for any reason, such termination shall not constitute termination of any of Company's other products, plans or programs.

5. MEDICARE REQUIRED PROVISIONS. Provider agrees to comply with all of the provisions of Schedule 1, attached hereto and incorporated into this Addendum.

6. PROVIDER OBLIGATIONS.
A. Provision of Covered Services. Provider agrees to provide to Medicare Members the health care services for which Provider is licensed and customarily provides in accordance with accepted medical and surgical standards in the community. Provider shall make Covered Services available and accessible to Medicare Members, including telephone access to Provider, on a twenty-four (24) hours, seven (7) days per week basis.

B. Provider agrees that all Medicare Services and other activities performed by Provider under the Agreement will be consistent and comply with Company's obligations as a Medicare Advantage Organization under Company's contracts with CMS. Upon request, Provider shall immediately provide to Company any information that is required by Company to meet its reporting obligations to CMS, including without limitation, physician incentive plan information, if applicable. To the extent that Provider generates and/or compiles and provides any data to Company that Company, in turn, submits to CMS, Provider certifies, to the best of its knowledge and belief, that such data is accurate, complete and truthful. Provider agrees to cooperate with and participate in internal and external review procedures necessary to allow Company to process Medicare appeals and grievances in accordance with Medicare laws, regulations and CMS instructions.

C. Federal Fund Obligations. Provider understands and agrees that payments received by Company for the Medicare Plans from CMS pursuant to the Medicare Plan's contract with CMS are Federal funds. As a result, Provider, by entering into this Agreement and the terms of this Addendum, is subject to laws applicable to individuals/entities receiving Federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R. part 84, the Age Discrimination Act of 1975 as implemented by regulations at 45 C.F.R. part 91, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

D. Continuation of Services. In the event Company's Medicare contract for the Medicare Plans with CMS terminates or Company becomes insolvent, Provider shall continue to provide Covered Services to Medicare Members who are hospitalized through the later of: (a) the date for which premiums were paid, or (b) through the date of discharge. Provider is prohibited by law from billing Medicare Members for such Covered Services. This provision shall survive the termination of this Agreement or Addendum, regardless of the reason for termination, including the insolvency of Company, and shall supersede any oral or written agreement between Provider and a Medicare Member.

E. Policies, Programs & Procedures. Provider agrees to comply with Company's policies and procedures (which Company shall provide to Provider upon request) which operationalize many of the requirements of the Agreement, this Addendum, and the Medicare Program. Provider agrees to comply with Company's quality improvement, administrative processes and procedures, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures, and any other policies Company may implement, including amendments made to the above mentioned policies, procedures and programs from time to time. In the event that a Company policy or procedure conflicts with a provision in the Agreement, then the language in the Agreement (including all amendments, exhibits, and attachments thereto) shall govern.

F. Maintenance of Records. Provider shall preserve records applicable to Medicare Members or to Company's participation in the Medicare Program, for the longer of: (i) the period of time required by State and Federal law, or (ii) ten (10) years, whichever is longer. In addition, to the extent applicable to Provider, Provider, on behalf of itself and any Downstream Entities with whom Provider has contracted, agrees to comply with 42 C.F.R. §422.2480(c)

and to maintain all records containing data used by Company to calculate Medicare medical loss ratios ("MLRs") for Company's Medicare Products and/or evidence needed by Company and/or federal governmental authorities with jurisdiction to validate MLRs (collectively, "MLR Records") for a minimum of ten (10) years from the date such MLRs were reported by Company to CMS.

G. Subcontractors. Provider shall require all of its subcontractors, if any, to comply with all applicable Medicare laws, regulations and CMS instructions.

(1) Provider shall include in Provider's contracts with subcontractors all of the contractual and legal obligations required by Company or the laws, regulations, rules and directions of CMS, including, without limitation, that any delegated services or activities to be performed by subcontractor shall be consistent and comply with the obligations in the contract between CMS and Company governing Company's participation in the Medicare Program. To the extent CMS requires additional provisions to be included in such subcontracts, Provider shall amend its contracts accordingly.

(2) Provider shall ensure that any vendors, subcontractors or other such entities that have a need to know the terms of the Agreement also maintain the privacy and confidentiality of all financial terms of the Agreement.

(3) If Provider arranges for the provision of Covered Services from other health care providers for Medicare Members, such contracts shall be in writing and shall specify the delegated activities and reporting responsibilities, in addition to meeting the requirements described above. In the event that Company delegates to Provider the selection of providers, Company retains the right to approve, suspend or terminate such delegation. If Company delegates the selection of providers, Company will either review the credentials of medical professionals affiliated with Provider or Company will review, approve, and audit on an ongoing basis Provider's credentialing process. The term "Subcontractor" as used in this Section shall not refer to employees or other individuals that perform services on behalf of Provider for which Provider bills such services under this Agreement. Provider represents and warrants that such persons are subject to all terms and conditions of this Agreement and Provider shall provide written evidence of such as described in the Agreement.

H. Contracts with Excluded Entities. Provider understands and agrees that no person that provides health care services under this Agreement, or persons that provide utilization review, medical social work or administrative services in support of services billed under this Agreement by Provider may be an individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. Provider hereby certifies that no such excluded person will provide such services under this Agreement and no such excluded persons will be employed by or utilized by any Downstream Entity with which Provider contracts relating to the furnishing of these services to Medicare Members. In accordance with applicable laws, rules and regulations and the Compliance Program Guidelines, Provider agrees to review the Department of Health and Human Services ("HHS") Office of Inspector General List of Excluded Individuals and Entities and the General Service Administrative Excluded Parties Lists System (collectively, "Exclusion Lists") to ensure that Provider Related Parties are not included on such Exclusion Lists. Provider agrees to review the Exclusion Lists prior to initially hiring, appointing or contracting with any new Provider Related Party and at least once per month thereafter to confirm that Provider Related Parties are not included on such Exclusion Lists. Provider agrees that if a Provider Related Party appears on an Exclusion List and/or is excluded from participation in any federally-funded health program, Provider will immediately remove the Provider Related Party from any work related directly or indirectly to Company's Medicare Plans, and take all corrective actions required under applicable laws, rules or regulations. In the event Provider or any Provider Related Parties are listed in an Exclusion List after the Effective Date of this Addendum, Company shall have the right, in its sole discretion and judgment, to terminate this Addendum in accordance with the Agreement or to disqualify the listed person(s) from providing any part of the Covered Services. For the purpose of this section "Provider Related Parties" means Provider's permanent and temporary employees and Downstream Entities that are involved in the performance of Medicare Services.

I. Offshore Services. Provider is prohibited from using any individual or entity ("Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative or other individual or entity) to perform any services for Medicare Plans if the individual or entity is physically located outside of one of the fifty

United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands) ("Offshore Services"), unless Company, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity. Provider further agrees that Company has the right to audit any Offshore Entity prior to the provision of Offshore Services for Medicare Plans. Additionally, Provider acknowledges and agrees that Offshore Services that involve Medicare Member protected health information (PHI) are subject to CMS reporting within thirty (30) days of: (1) performing, or contracting with an Offshore Entity to perform, Offshore Services, and (2) any time Provider changes the Offshore Services that an Offshore Entity will perform.

J. Submission of Encounter Data. Provider hereby acknowledges that Company is required to provide CMS and other federal and state regulatory agencies and accrediting organizations with encounter data as requested by such agencies and organizations. Such data may include medical records and all other data necessary to characterize each encounter between Provider and a Medicare Member. Provider agrees to cooperate with Company and to provide Company with all such information in such form and manner as requested by Company. Provider agrees to immediately notify Company if any encounter data that Provider submitted to Company for Medicare Members is inaccurate, incomplete or erroneous, and cooperate with Company to correct erroneous encounter data to ensure Company's compliance with Medicare laws, rules and regulations and CMS instructions.

K. Certification of Data. Provider recognizes that as a Medicare Advantage organization, Company is required to certify the accuracy, completeness and truthfulness of data that CMS requests. Such data include encounter data, payment data, and any other information provided to Company by its contractors and subcontractors. Provider and its subcontractors, if any, hereby certify that any such data submitted to Company will be accurate, complete and truthful. Upon request, Provider shall make such certification in the form and manner prescribed by Company.

L. Medicare Member Complaints. Provider agrees to cooperate with Company in resolving any Medicare Member complaints related to coverage for the provision of Covered Services. Company will notify Provider as necessary concerning all Medicare Member complaints involving Provider. Provider shall, in accordance with the Provider's regular procedures, investigate such complaints and respond to Company in the required time. Provider shall use best efforts to resolve complaints in a fair and equitable manner.

M. Compliance Program and Anti-Fraud Initiatives. Provider shall (and shall cause its subcontractors to) institute, operate, and maintain an effective compliance program to detect, correct and prevent the incidence of non-compliance with CMS requirements and the incidence of fraud, waste and abuse (FWA) relating to the operation of Company's Medicare Program. Such compliance program shall be appropriate to Provider's or subcontractor's organization and operations and shall include: (a) written policies, procedures and standards of conduct articulating the entity's commitment to comply with federal and state laws, as well as providing mechanisms for employee/subcontractor use in adhering to the expectation that Provider and employee/subcontractor report potential non-compliance or FWA issues (internally and to Company, as applicable); (b) for all officers, directors, employees, contractors and agents of Provider or subcontractor, required participation in effective compliance and anti-fraud training and education that is consistent with guidance that CMS has or may issue with respect to compliance and anti-fraud and abuse initiatives, unless exempt from such training under relevant CMS regulations. This includes general compliance and FWA training completion, as well as code of conduct dissemination, initially within ninety (90) days of hire/contracting and at least annually thereafter; Provider and subcontractors, as applicable, may use Company's code and training or an equivalent; and (c) processes to oversee subcontractors to ensure their compliance with these requirements.

N. Marketing. Consistent with Federal laws, regulations, and agency requirements applicable to the Medicare Advantage Program, Provider shall not: (1) engage in any marketing or sales activities that could mislead or confuse Medicare beneficiaries, or (2) market or advertise non-health care related products to Medicare Members or prospective Medicare Members. Further, Provider shall at all times comply with the then current Medicare Marketing Guidelines.

O. Dual-Eligible Hold Harmless. Provider acknowledges and agrees that Medicare Members who are also enrolled in a State Medicaid plan ("Dual Eligible Members") are not responsible for paying to Provider any Copayments, Coinsurance or Deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when the State Medicaid plan is responsible for paying such Cost Sharing Amounts. Provider further agrees that they will

not collect Cost Sharing Amounts from Dual Eligible Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the Company's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts, or bill the applicable State Medicaid plan for the appropriate Cost Sharing Amounts owed by the State Medicaid plan.

7. COMPANY OBLIGATIONS.
A. Fee Schedule. Company shall arrange for Provider to be compensated for health care services rendered to Medicare Members in accordance with Section 2 of this Addendum.

B. Prompt Pay. In accordance with 42 C.F.R. § 422.520(a)(1), Company shall make best efforts to pay clean claims submitted by Provider for Covered Services provided to Medicare Members within thirty (30) calendar days of receipt. For purposes of this Addendum, the term "clean claim" shall have the meaning assigned in 42 C.F.R. §422.500.

8. GENERAL PROVISIONS
A. Termination. This Addendum may be terminated on its own without respect to the remainder of the Agreement with or without cause by either Party in accordance with the termination provisions of the underlying Agreement. This Addendum shall terminate automatically in the event that the underlying Agreement is terminated in accordance with the termination provisions of the Agreement.

B. Governing Law. This Addendum shall be governed by Federal laws, regulations, and agency requirements applicable to the Medicare Advantage Program. In the event that changes to the governing laws, regulations, or agency requirements applicable to the Medicare Advantage Program occur, the new law, regulation or agency requirement shall supersede to the extent required by any such later required changes.

C. All other terms and provisions of the Agreement not amended hereby shall remain in full force and effect, without modification. In the event of any inconsistency between the terms of this Addendum and the Agreement, the terms of this Addendum shall govern and control.

D. Survival. All provisions of this Addendum which by their nature should survive termination of Provider's provision of Medicare Services under this Agreement or termination of the Agreement as a whole, shall survive termination.

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Schedule 1

Medicare Required Provisions

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement between Company and Provider (referred to in this Schedule 1 as "FDR") not inconsistent herein shall remain in full force and effect. This Exhibit shall supersede and replace any inconsistent provisions to such Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

NOW, THEREFORE, the parties agree as follows:

A. Definitions:

1. Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

2. Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

3. Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

4. Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

5. First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

6. Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

7. Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

8. Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

9. Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

10. Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes

services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

B. <u>Required Provisions</u>:

FDR agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with Company's Affiliates included in this Agreement, (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)] and [42 CFR §423.505]

2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph 1 of this amendment directly from any first tier, downstream, or related entity. For records subject to review under paragraph 1, except in exceptional circumstances, CMS will provide notification to the MA organization that a direct request for information has been initiated. [42 C.F.R. §§ 422.504(i)(2)(ii) and (iii)]

3. FDR will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118] and [42 CFR §423.136]

4. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)] and [42 CFR §423.505(i)(3)(i)]

5. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. FDR may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

6. Any services or other activity performed in accordance with a contract or written agreement by FDR are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)] and [42 CFR §423.505(i)(3)(iii)]

7. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between the MA Organization/Physician and the provider. [42 C.F.R. §§ 422.520(b)(1) and (2)]
   See Section 7.b of the Addendum to which this Schedule 1 is attached.

8. FDR and any related entity, contractor or subcontractor will comply with all applicable Federal and Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)] and [42 CFR §423.505(i)(4)(iv)]

9. If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity:

[INFORMATIONAL NOTE: If there is no delegation of a specific activity or responsibility, please delete the related provision and replace with "None delegated".]

(i) The delegated activities and reporting responsibilities are specified as follows:

[List activities and reporting responsibilities or enter the section and name of the delegation or applicable agreement].

(ii) CMS and the MA organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.

(iii) The MA organization will monitor the performance of the parties on an ongoing basis.

[Enter any applicable section and name of the delegation or applicable agreement].

(iv) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.

[**Enter any applicable section and name of the delegation or applicable agreement].**

(v) If the MA organization delegates the selection of providers, contractors, or subcontractor, the MA organization retains the right to approve, suspend, or terminate any such arrangement.

[42 C.F.R. §§ 422.504(i)(4) and (5)]

In the event of a conflict between the terms and conditions above and the terms of a related agreement, the terms above control.

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Aetna Better Health of Iowa
Facility Services Agreement

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Aetna Better Health of Iowa

Facility Services Agreement Checklist

_____ **All** pages of this document must be printed and returned to Aetna Better Health (not just the signature pages).

_____ **Page 1**. The Facility name that is filled in on the top of page one must match **exactly** with the name on the W9. Leave the effective date blank. This will be filled in by Aetna Better Health.

_____ **Signature Page.** The signature page must be signed by an authorized Facility representative. In addition, all information listed below the signature line (TIN, NPI, and Reimbursement Address, etc.) must be completed.

_____ **Facility Application**. The Aetna Better Health Facility Application must be completed and returned with the signed contract.

_____ **W9**. A W9 form must be returned with the contract. As indicated above, the name on the W9 must match exactly the name listed on pages 1 and the signature page of the Agreement.

Please return all documents to:

Aetna Better Health of Iowa
Attn: Network Management
4320 NW 114th Street
Urbandale, IA 50322

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AETNA BETTER HEALTH OF IOWA
FACILITY SERVICES AGREEMENT

The term of this Medicaid Facility Services Agreement (the "Agreement") by and between Aetna Better Health of Iowa Inc., an Iowa corporation on behalf of itself and its Affiliates (hereinafter "Company"), and _____ (hereinafter "Facility"), shall commence effective _____, 20___ [Date to be completed by Company] (the "Effective Date"). Company and Provider may be referred to individually as a "Party" and collectively as the "Parties." The Regulatory Compliance Addendum (Exhibit A) and Medicare Compliance Addendum (Exhibit D, including Schedule 1) attached to this Agreement, are expressly incorporated into this Agreement and are binding upon the Parties. In the event of any inconsistent or contrary language between the Addenda and any other part of this Agreement, including but not limited to exhibits, attachments or amendments, the Parties agree that the provisions of the Addenda shall prevail.

WHEREAS, Company administers Plans for Government Sponsors that provide access to health care services to Members or arranges for the provision of health care services to Members of Government Programs; and

WHEREAS, Company contracts with certain health care providers and facilities to provide access to such health care services to Members; and

WHEREAS, Facility provides health care services to patients within the scope of its licensure or accreditation; and

WHEREAS, Company and Facility mutually desire to enter into an arrangement whereby Facility will become a Participating Provider and render health care services to Members; and

WHEREAS, in return for the provision of health care services by Facility, Company will pay Facility for Covered Services under the terms of this Agreement; and

WHEREAS, Facility understands and agrees that Government Sponsors or other government entities may require certain changes to the terms of this Agreement before Facility can provide services to Members under the terms of any Plans that are awarded, by the Government Sponsors, to Company.

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants, promises and undertakings herein, the sufficiency of which is hereby acknowledged, and intending to be legally bound hereby, the parties agree as follows:

1.0 DEFINITIONS

When used in this Agreement, all capitalized terms shall have the following meanings:

Affiliate. Any corporation, partnership or other legal entity (including any Plan) directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company.

Clean Claim. A claim that can be processed without obtaining additional information from the Facility who provided the service or from a third party, except that it shall not mean a claim submitted by or on behalf of a Facility who is under investigation for fraud or abuse, or a claim that is under review for medical necessity; provided, further, unless otherwise required by law or regulation, a claim which (a) is submitted within the proper timeframe as set forth in this Agreement and (b) has (i) detailed and descriptive medical and patient data, (ii) a corresponding referral (whether in paper or electronic format), if required for the applicable claim, (iii) whether submitted via an electronic transaction using permitted standard code sets (e.g., CPT-4, ICD-9 (or successor standard), HCPCS) as required by the applicable Federal or state regulatory authority (e.g., U.S. Dept. of Health & Human Services, U.S. Dept. of Labor, state law or regulation) or otherwise, all the data elements of the UB-04 or CMS-1500 (or successor standard) forms (including but not limited to Member identification number, national provider identifier ("NPI"), date(s) of service, complete and accurate breakdown of services), and (c) does not involve coordination of benefits, and (d) has no defect or error (including any new procedures with no CPT code,

experimental procedures or other circumstances not contemplated at the time of execution of this Agreement) that prevents timely adjudication.

Coinsurance. A payment a Member is required to make under a Plan which is determined as a percentage of the lesser of: (a) the rates established under this Agreement; or (b) Facility's usual, customary and reasonable billed charges.

Confidential Information. Any information that identifies a Member and is related to the Member's participation in a Plan, the Member's physical or mental health or condition, the provision of health care to the Member or payment for the provision of health care to the Member. Confidential Information includes, without limitation, "individually identifiable health information", as defined in 45 C.F.R. § 160.103 and "non-public personal information" as defined in laws or regulations promulgated under the Gramm-Leach-Bliley Act of 1999.

Copayment. A charge required under a Plan that must be paid by a Member at the time of the provision of Covered Services, or at such other time as determined by Facility and which is expressed as a specific dollar amount.

Covered Services. Those health care services for which a Member is entitled to receive coverage under the terms and conditions of a Plan. The Parties agree that Company is obligated to pay for only those Covered Services that are determined to be medically necessary, as determined in accordance with the Member's applicable Plan.

Deductible. An amount that a Member must pay for Covered Services during a specified coverage period in accordance with the Member's Plan before benefits will be paid.

Effective Date. Defined in first paragraph of this Agreement.

Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, her pregnancy or health or the health of her fetus) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part; or such other definition as may be required by applicable law.

Emergency Services. Covered Services furnished by a qualified provider and necessary to evaluate or stabilize an Emergency Medical Condition.

Facility. Defined in first paragraph of this Agreement.

Facility Services. Defined in Section 2.1 of this Agreement.

Government Programs. Plans operated and/or administered by Company pursuant to a State Contract.

Government Sponsor. A state agency or other governmental entity authorized to offer, issue and/or administer one or more Plans, and which, to the extent applicable, has contracted with Company to administer all or a portion of such Plan(s).

Material Change. Any change in Policies that could reasonably be expected, in Company's determination, to have a material adverse impact on (i) Facility's reimbursement for Facility Services or (ii) Facility administration.

Medically Necessary or Medical Necessity. Those Health care services that a physician or other applicable health care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical

practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendation and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member. An individual covered by or enrolled in a Plan.

Participating Provider. Any physician, hospital, hospital-based physician, skilled nursing facility, mental health and/or substance abuse professional (which shall include psychiatrists, psychologists, social workers, psychiatric nurses, counselors, family or other therapists or other mental health/substance abuse professionals), or other individual or entity involved in the delivery of health care or ancillary services who or which has entered into and continues to have a current valid contract with Company to provide Covered Services to Members, and, where applicable, has been credentialed by Company or its designee consistent with the credentialing policies of Company or its designee, as applicable. Certain categories of Participating Providers may be referred to herein more specifically as, e.g., "Participating Physicians" or "Participating Hospitals."

Party. Company or Facility, as applicable. Company and Facility may be referred to collectively as the "Parties."

Plan. A Member's health care benefits as set forth in the State Contract. Such Plans are listed in the **Program Participation Schedule** attached hereto and made a part hereof.

Policies. The policies and procedures promulgated by Company which relate to the duties and obligations of the Parties under the terms of this Agreement, including, but not limited to: (a) quality improvement/management; (b) utilization management, including, but not limited to, precertification of elective admissions and procedures, concurrent review of services and referral processes or protocols; (c) pre-admission testing guidelines; (d) claims payment review; (e) member grievances; (f) provider credentialing; (g) electronic submission of claims and other data required by Company; and (h) any applicable participation criteria required by the State in connection with the Government Programs. Policies also include those policies and procedures set forth in the Company's and/or Government Sponsor's manuals (as modified from time to time) as Company determines appropriate in its sole discretion; clinical policy bulletins made available via Company's internet web site; and other policies and procedures, whether made available via a password-protected web site for Participating Providers (when available), by letter, newsletter, electronic mail or other media.

Post-Stabilization Care Services. Covered Services relating to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, under circumstances defined in federal regulations, to improve or resolve the Member's condition.

Proprietary Information. Any and all information, whether prepared by a Party, its advisors or otherwise, relating to such Party or the development, execution or performance of this Agreement whether furnished prior to or after the Effective Date. Proprietary Information includes but is not limited to, with respect to Company, the development of a pricing structure, (whether written or oral) all financial information, rate schedules and financial terms which relate to Facility and which are furnished or disclosed to Facility by Company. Notwithstanding the foregoing, the following shall not constitute Proprietary Information:

(a) information which was known to a receiving Party (a "Recipient") prior to receipt from the other Party (a "Disclosing Party") (as evidenced by the written records of a Recipient);

(b) information which was previously available to the public prior to a Recipient's receipt thereof from a Disclosing Party;

(c) information which subsequently became available to the public through no fault or omission on the part of a Recipient, including without limitation, the Recipient's officers, directors, trustees, employees, agents, contractors and other representatives;

(d) information which is furnished to a Recipient by a third party which a Recipient confirms, after due inquiry, has no confidentiality obligation, directly or indirectly, to a Disclosing Party; or

(e) information which is approved in writing in advance for disclosure or other use by a Disclosing Party.

Specialty Program. A program for a targeted group of Members with certain types of illnesses, conditions, cost or risk factors.

Specialty Program Providers. Those hospitals, physicians and other providers that have been identified or designated by Company or the Government Sponsor to provide Covered Services associated with a Specialty Program.

State Contract. Company's contract(s) with Government Sponsors to administer Plans or Government Programs identified in the **Program Participation Schedule**.

2.0 FACILITY SERVICES AND OBLIGATIONS

2.1 Provision of Services.
Facility will make available and provide to Members Covered Services, including facilities, equipment, personnel or other resources necessary to provide such Covered Services according to generally accepted standards of Facility's practice ("Facility Services"). Upon written notice from Facility, Company may agree to add new or relocating facilities and locations to this Agreement upon completion of applicable credentialing and satisfaction of all other requirements of Company. Other demographic information may be revised upon written notice from Facility.

2.2 Non-Discrimination and Equitable Treatment of Members.
Facility agrees to provide Facility Services to Members with the same degree of care and skill as customarily provided to Facility's patients who are not Members, according to generally accepted standards of Facility's practice. Facility and Company agree that Members and non-Members should be treated equitably. Facility agrees not to discriminate against Members on the basis of race, ethnicity, gender, creed, ancestry, lawful occupation, age, religion, marital status, sexual orientation, mental or physical disability, medical history, color, national origin, place of residence, health status, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment for services, cost or extent of Facility Services required, or any other grounds prohibited by law or this Agreement and will abide by Company's cultural competency Policies. Facility shall deliver Covered Services in a culturally competent manner to Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds, and comply with Company's Policies on cultural competency.

2.3 Federal Law.
Company is a Federal contractor and an Equal Opportunity Employer which maintains an Affirmative Action Program. To the extent applicable to Facility, Facility, on behalf of itself and any subcontractors, agrees to comply with the following, as amended from time to time: Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq., and regulations promulgated thereunder, Executive Order 11246, the Vietnam Era Veterans Readjustment Act of 1974, the Drug Free Workplace Act of 1988, Section 503 of the Rehabilitation Act of 1973, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") administrative simplification rules at 45 CFR parts 160, 162, and 164, the Americans with Disabilities Act of 1990, Federal laws, rules and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (Section 1128B(b) of the Social Security Act), and any similar laws, regulations or other legal mandates applicable to recipients of federal funds and/or transactions under or otherwise subject to any government contract of Company.

2.4 Facility Representations.

2.4.1 General Representations. Facility represents, warrants and covenants, as applicable, that: (a) it has and shall maintain throughout the term of this Agreement all appropriate license(s) and certification(s) mandated by governmental regulatory agencies; (b) it is, and will remain throughout the term of this Agreement, accredited by The Joint Commission, American Association for Accreditation of Ambulatory Surgery Facilities ("AAAASF"); American Osteopathic Association's Healthcare Facilities Accreditation Program ("HFAP"); or another applicable accrediting agency recognized by Company; (c) it is, and will remain throughout the term of this Agreement, in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided hereunder, including, without limitation, statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, false claims and prohibition of kickbacks; (d) it is certified to participate in the Medicaid and Medicare programs; (e) it has established an ongoing quality assurance/assessment program which includes, but is not limited to, appropriate credentialing of employees and subcontractors and shall supply to Company the relevant documentation, including, but not limited to, internal quality assurance/assessment protocols, state licenses and certifications, Federal agency certifications and/or registrations upon request; (f) all ancillary health care personnel employed by, associated or contracted with Facility who treat Members ("Ancillary Personnel"): (i) are and will remain throughout the term of this Agreement appropriately licensed and/or certified (when and as required by state law) and supervised, and qualified by education, training and experience to perform their professional duties; and (ii) will act within the scope of their licensure or certification, as the case may be; (g) its credentialing, privileging, and re-appointment procedures are in accordance with its medical staffs by-laws, regulations, and policies, comply with The Joint Commission standards, meet the querying and reporting requirements of the National Practitioner Data Bank ("NPDB") and Healthcare Integrity and Protection Data Bank ("HIPDB"), and fulfill all applicable state and Federal standards; (h) this Agreement has been executed by its duly authorized representative; and (i) executing this Agreement and performing its obligations hereunder shall not cause Facility to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

2.4.2 Government Program Representations. Company has or shall seek contracts to serve beneficiaries of Government Programs. To the extent Company participates in such Government Programs, Facility agrees, on behalf of itself and any subcontractors of Facility acting on behalf of Facility, to be bound by all rules and regulations of, and all requirements applicable to, such Government Programs. Facility acknowledges and agrees that all provisions of this Agreement shall apply equally to any employees, independent contractors and subcontractors of Facility who provide or may provide Covered Services to Members of Government Programs, and Facility represents and warrants that Facility shall cause such employees, independent contractors and subcontractors to comply with this Agreement, the State Contract, and all applicable laws, rules and regulations and perform all requirements applicable to Government Programs. Any such subcontract or delegation shall be subject to prior written approval by Company. With respect to Members of Government Programs, Facility acknowledges that compensation under this Agreement for such Members constitutes receipt of Federal funds. Facility agrees that all services and other activities performed by Facility under this Agreement will be consistent and comply with the obligations of Company and/or Government Sponsor under its contract(s) with the Centers for Medicare and Medicaid Services ("CMS"), and any applicable state regulatory agency, to offer Government Program. Facility further agrees to allow Government Sponsor, CMS, any applicable state regulatory agency, and Company to monitor Facility's performance under this Agreement on an ongoing basis in accordance with applicable laws, rules and regulations. Facility acknowledges and agrees that Company may only delegate its activities and responsibilities under the State Contract or any Company contract(s) with Government Sponsor, CMS and any applicable regulatory agency, to offer Government Program in a manner consistent with applicable laws, rules and regulations, and that if any such activity or responsibility is delegated by Company to Facility, the activity or responsibility may be revoked if Government Sponsor, CMS or Company determine that Facility has not performed satisfactorily. Upon request, Facility shall immediately provide to Company any information that is required by Company to meet its reporting obligations to CMS, including without limitation, physician incentive plan information, if applicable. To the extent that Facility generates and/or compiles and provides any data to Company that Company, in turn, submits to CMS, Facility certifies, to the best of its knowledge and belief, that such data is accurate, complete and truthful.

2.4.3 Government Program Requirements. Facility, on behalf of itself and each Facility-based Physician, hereby agrees to perform its obligations under this Agreement in accordance with the terms and conditions set forth in Exhibits A, B & D, as applicable.

2.4.4 Qualified Providers. Facility shall exclude any physician or other provider from performing services in connection with this agreement if such provider has been suspended or terminated from participation in Government Programs or any other government-sponsored program, including Medicare or the Medicaid program in any state. Facility is prohibited from using any individual or entity ("Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative or other individual or entity) to perform any services for Plans if the individual or entity is physically located outside of one of the fifty United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands.), unless Company, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity. Facility further agrees that Company has the right to audit any Offshore Entity prior to the provision of services for Plans.

2.4.5 Suspension or Debarment. Facility represents, warrants and covenants, as applicable, that it and each Facility-based Physician:

a. Has not within a three year period preceding the proposal submission been convicted or had a civil judgment rendered against him/her/it for commission of fraud or criminal offense in performing a public transaction or contract (local, state or federal) or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property; and

b. Is not presently indicted for or otherwise criminally or civilly charged by a governmental entity with the commission of any of the above offenses; and

c. Has not within a five year period preceding execution of this Agreement had one or more public transactions terminated for cause or fault; and

d. Is not excluded, debarred or suspended from participation in any government-sponsored program including, but not limited to, Government Programs, Medicare or the Medicaid program in any state; and

e. Will immediately report any change in the above status to Company; and

f. Will maintain all appropriate licenses to perform its duties and obligations under the Agreement.

2.5 Facility's Insurance.
During the term of this Agreement, Facility agrees to procure and maintain such policies of general and professional liability and other insurance, or a comparable program of self-insurance, at minimum levels as required by state law or, in the absence of a state law specifying a minimum limit, an amount customarily maintained by Facility in the state or region in which the Facility operates. Such insurance coverage shall cover the acts and omissions of Facility as well as those Facility's agents and employees. Facility agrees to deliver certificates of insurance or other documentation as appropriate to show evidence of such coverage to Company upon request. Facility agrees to make best efforts to provide to Company at least thirty (30) days advance notice, and in any event will provide notice as soon as reasonably practicable, of any cancellation or material modification of said policies.

2.6 Product Participation.
Facility agrees to participate in the Plans and other health benefit programs listed on the **Program Participation Schedule**. Company reserves the right to introduce and designate Facility's participation in new Plans, Specialty Programs and other programs during the term of this Agreement and will provide

Facility with written notice of such new Plans, Specialty Programs and other programs and the associated compensation. To the extent that Company establishes and/or participates in a provider Pay-for-Performance incentive program or Performance Improvement Programs, Facility agrees to comply with and participate in such program.

Nothing herein shall require that Company identify, designate or include Facility as a preferred participant in any specific Plan for which Company provides incentives based upon the use of selected participating facilities, Specialty Program or other program; provided, however, Facility shall accept compensation in accordance with this Agreement for the provision of any Covered Services to Members under a Plan, Specialty Program or other program in which Facility has agreed to participate hereunder.

2.7 Consents to Release Medical Information.
Facility covenants that it will obtain from Members to whom Facility Services are provided, any necessary consents or authorizations to the release of Information and Records to Company, Government Sponsors, their agents and representatives in accordance with any applicable Federal or state law or regulation or this Agreement.

3.0 COMPANY OBLIGATIONS

3.1 Company's Covenants.
Company or Government Sponsors shall provide Members with a means to identify themselves to Facility (e.g., identification cards), explanation of provider payments, a general description of products (e.g. Quick Reference Card), a listing of Participating Providers, and timely notification of material changes in this information. Company shall provide Facility with a means to check eligibility. Company shall include Facility in the Participating Provider directory or directories for the Plans, Specialty Programs and products in which Facility is a Participating Provider, including when Facility is designated as preferred participant, and shall make said directories available to Members. Company reserves the right to determine the content of provider directories.

3.2 Company Representations.
Company represents and warrants that: (a) this Agreement has been executed by its duly authorized representative; and (b) executing this Agreement and performing its obligations hereunder shall not cause Company to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

The parties acknowledge that one or more state governmental authorities may recommend or require that various Company agreements, including this Agreement, be executed prior to the issuance to Company of one or more approvals, consents, licenses, permissions or other authorizations from governmental authorities with jurisdiction over the subject matter of this Agreement, or which Company deems to be necessary or desirable in its sole discretion (collectively, a "License"). Facility agrees that all Company obligations to perform, and all rights of Facility, under this Agreement are expressly conditioned upon the receipt of all Licenses. Failure of Company to obtain any License shall impose no liability on Company under this Agreement.

3.3 Company's Insurance.
Company at its sole cost and expense agrees to procure and maintain such policies of general and/or professional liability and other insurance (or maintain a self-insurance program) as shall be necessary to insure Company and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any service by Company under this Agreement and the administration of Plans.

4.0 CLAIMS SUBMISSIONS, COMPENSATION AND MEMBER BILLING

4.1 Claim Submission and Payment.

4.1.1 Facility Obligation to Submit Claims. Facility agrees to submit Clean Claims to Company for Facility Services rendered to Members. Facility agrees to submit claim and encounter data related to a Member enrolled in a Government Program in the form and manner as specified by Company, and, Facility certifies that any such data is accurate, complete and truthful. Facility will make best commercial efforts to submit a minimum of eighty-five percent (85%) of its Member claims electronically to Company. Facility represents that, where necessary, it has obtained signed assignments of benefits authorizing payment for Facility Services to be made directly to Facility. For claims Facility submits electronically, Facility shall not submit a claim to Company in paper form unless Company requests paper submissions or fails to pay or otherwise respond to electronic claims submission in accordance with the time frames required under this Agreement or applicable law or regulation. Facility agrees that Company, or the applicable Government Sponsor, will not be obligated to make payments for billings received more than one hundred and twenty (120) days (or such other period required by applicable state law or regulation)from (a) the date of service or, (b) when Company is the secondary payer, from the date of receipt of the primary payer's explanation of benefits. Company may waive this requirement if Facility provides notice to Company, along with appropriate evidence, of other extraordinary circumstances outside the control of Facility that resulted in the delayed submission. In addition, unless Facility notifies Company of its payment disputes within one hundred eighty (180) days, or such other time as required by applicable state law or regulation, of receipt of payment from Company, such payment will be considered full and final payment for the related claims. If Facility does not timely bill Company or Government Sponsors, or dispute any payment, timely as provided in this Section 4.1.1, Facility's claim for payment will be deemed waived and Facility will not seek payment from Government Sponsors, Company or Members. Facility shall pay on a timely basis all Participating Providers, employees, independent contractors and subcontractors who render Covered Services to Members of Company's Plans for which Facility is financially responsible pursuant to this Agreement.

Facility agrees to permit claim editing to the primary procedure those services considered part of, incidental to, or inclusive of the primary procedure and make other adjustments for inappropriate billing or coding (e.g., rebundling, duplicative procedures or claim submissions, mutually exclusive procedures, gender/procedure mismatches, age/procedure mismatches). To the extent Facility is billing on a CMS 1500, as of the Effective Date, in performing adjustments for inappropriate billing or coding, Company utilizes a commercial software package (as modified by Company for all Participating Providers in the ordinary course of Company's business) which commercial software package relies upon Government Programs and other industry standards in the development of its rebundling logic.

Subject to applicable law: (i) Company may update internal payment systems in response to additions, deletions, and changes to Government Sponsor, CMS, or other industry source codes without obtaining any consent from Facility or any other party, and Company will provide, at the written request of Facility, a copy of the fee schedule in effect at the time of such request; (ii) Company shall not be responsible for communicating such routine changes of this nature, and will update any applicable payment schedules on a prospective basis within ninety (90) days from the date of publication or such longer period as Company determines appropriate in its sole discretion; and (iii) Company shall have no obligation to retroactively adjust claims.

4.1.2 Company Obligation to Pay for Covered Services. Company shall make payments to Facility for Covered Services on a timely basis consistent with the claims payment procedure described at 42 U.S.C. § 1396a(a)(37)(A). Company agrees to pay Facility for non-capitated Covered Services rendered to Members according to the lesser of (i) Facility's actual billed charges or (ii) the rates set forth in the **Services and Compensation Schedule**, attached hereto and made a part hereof. Company must pay ninety percent (90%) of all such Clean Claims from Facility within thirty (30) days following actual receipt; provided, further, Company must pay ninety-nine percent (99%) of all Clean Claims from Facility within ninety (90) days following actual receipt.. Facility will make best commercial efforts to utilize online explanation of benefits or electronic remittance of advice (or combination thereof) and electronic funds transfer in lieu of receiving paper equivalents to the extent such services are available from Company. Company reserves the right to recoup any overpayment or payment

made in error (e.g., a duplicate payment or payment for services rendered by Facility to a patient who was not a Member and amounts identified through routine investigative reviews of records or audits) against any other monies due to Facility under this Agreement.

In the event that Facility identifies any overpayments by Company, Facility shall, as required under Section 6402(a) of the Patient Protection and Affordable Care Act, report and return any and all such overpayments to Company within sixty (60) days of Facility's identification of any and all such overpayments. In addition, when reporting and returning any such overpayments by Company, Facility must provide Company with a written reason for the overpayment (e.g., excess payment under coordination of benefits, etc.).

To the extent, if any, that the compensation under certain Plans is in the form of capitation payments or a case-based rate methodology, Facility acknowledges the financial risks to Facility of this arrangement and has made an independent analysis of the adequacy of this arrangement. Facility, therefore, agrees and covenants not to bring any action asserting the inadequacy of these arrangements or that Facility was in any way improperly induced by Company to accept the rate of payment, including, but not limited to, causes of actions for damages, rescission or termination alleging fraud or negligent misrepresentation or improper inducement. Notwithstanding anything in this Agreement to the contrary, subcontractors agree to seek compensation solely from Facility for those Covered Services provided to Members and for which Facility is compensated by Company. Subcontractor shall in no event bill Company, its Affiliates, Government Sponsor, or Members for any such Covered Services. Facility will provide Company with a Designation of Payment Schedule from all subcontractors, which will indemnify and hold harmless Company, Government Sponsor and its Members for payment of all compensation owed subcontractor under subcontractor's arrangement with Facility.

Complaints or disputes concerning payments for the provision of services as described in this Agreement shall be subject to the Company's grievance resolution system.

4.1.3 Eligibility Determinations. Company shall have the right to recover payments made to Facility if the payments are for services provided to an individual who is later determined to have been ineligible based upon information that is not available to Company at the time the service is rendered or authorization is provided

4.1.4 Utilization Management. The Parties agree that Company, on its behalf and on behalf of Government Sponsors, reserves the right to perform utilization management (including retrospective review) and to adjust or deny payment for the inefficient delivery of Facility Services related to admissions, or length of stay. To facilitate timely and accurate concurrent utilization management, Facility and Company will cooperate as necessary to facilitate on-site and/or concurrent telephonic utilization management at Facility. Company agrees that it will not conduct retrospective review so long as Company has been provided a reasonable opportunity to conduct full and complete concurrent utilization management review in accordance with Policies while the Member was in the Facility, except where (1) Facility, a Participating Provider or any other provider rendering care at or on behalf of Facility, has provided inaccurate or incomplete information to Company or (2) the patient was not a known Member as of the time of the provision of care.

4.2 Coordination of Benefits.

Except as otherwise required under applicable Federal, state law or regulation or a Plan, when Company or a Government Sponsor is secondary payer under applicable coordination of benefit principles, and payment from the primary payer is less than the compensation payable under this Agreement without coordination of benefits, then Company or Government Sponsor will pay Facility the lesser of (i) the copayment, coinsurance and deductible amount for the Covered Services as reported on the explanation of benefits of the primary payer, or (ii) the amount of the difference between the amount paid by the primary payer and the compensation payable under this Agreement, absent other sources of payment. Notwithstanding any other provision of this paragraph, if payment from the primary payer is greater than or equal to the compensation payable under this Agreement without coordination of benefits, neither Company, Government Sponsor nor

the applicable Member (in accordance with Section 4.3.2 below) shall have any obligation to Facility. Notwithstanding anything to the contrary in this section, in no event shall Facility collect more than Medicare allows if Medicare is the primary payer. Medicaid is never the primary payer.

4.3 Member Billing.

4.3.1 Permitted Billing of Members. Facility may bill or charge Members only in the following circumstances: (a) applicable Copayments, Coinsurance and/or Deductibles, if any, not collected at the time that Covered Services are rendered; and (b) for services that are not Covered Services only if: (i) the Member's Plan provides and/or Company confirms that the specific services are not covered; (ii) the Member was advised in writing prior to the services being rendered that the specific services may not be Covered Services; and (iii) the Member agreed in writing to pay for such services after being so advised. Facility acknowledges that Company's denial or adjustment of payment to Facility based on Company's performance of utilization management as described in Section 4.1.3 or otherwise is not a denial of Covered Services under this Agreement or under the terms of a Plan, except if Company confirms otherwise under this Section 4.3. Facility may bill or charge individuals who were not Members at the time that services were rendered.

4.3.2 Holding Members Harmless. Facility hereby agrees that in no event, including, but not limited to the failure, denial or reduction of payment by Company, insolvency of Company or breach of this Agreement, shall Facility bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse (i) against Members or persons acting on their behalf (other than Company) or (ii) any settlement fund or other *res* controlled by or on behalf of, or for the benefit of, a Member for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance, Deductibles made in accordance with the terms of the applicable Plan. Facility further agrees that this Section 4.3.2: (a) shall survive the expiration or termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) supersedes any oral or written contrary agreement or waiver now existing or hereafter entered into between Facility and Members or persons acting on their behalf.

4.3.3 Dual Eligible Members. Facility acknowledges and agrees that Members who are also enrolled in a State Medicaid plan ("Dual Eligible Members") are not responsible for paying to Facility any Copayments, Coinsurance or Deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when the State Medicaid plan is responsible for paying such Cost Sharing Amounts. Facility further agrees that they will not collect Cost Sharing Amounts from Dual Eligible Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the Company's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts, or, bill the applicable State source for the appropriate Cost Sharing Amounts owed by the State Medicaid plan. Dual Eligible Members in Capitated Financial Alignment Demonstration Plans are not responsible for Cost Sharing Amounts for Medicare Parts A and B services.

To protect Members, Facility agrees not to seek or accept or rely upon waivers of the Member protections provided by this Section 4.3.

5.0 COMPLIANCE WITH POLICIES

5.1 Policies.

Facility agrees to accept and comply with Policies of which Facility knows or reasonably should have known (e.g., Clinical Policy Bulletins or other Policies made available to Participating Providers). Except when a Member requires Emergency Services, Facility agrees to comply with any applicable precertification and/or referral requirements under the Member's Plan prior to the provision of Facility Services. Facility will utilize the electronic real time HIPAA compliant transactions, including but not limited to, eligibility, precertification and claim status inquiry transactions to the extent such electronic real time features are utilized by Company. Facility agrees to notify Company of all admissions of Members, and of all services for which Company requires notice, upon admission or prior to the provision of such services. For the

purpose of pre-admission testing, Facility agrees to directly provide testing or accept test results and examinations performed outside Facility provided such tests and examinations are: (a) performed by a state licensed laboratory for laboratory tests, and a licensed physician for such other tests and examinations; and (b) performed within a time reasonably proximate to the admission. For those Members who require services under a Specialty Program, Facility agrees to work with Company in transferring the Member's care to a Specialty Program Provider, as the case may be. Company may at any time modify Policies. Company will provide notice by letter, newsletter, electronic mail or other media, of Material Changes. Failure by Facility to object in writing to any Material Change within thirty (30) days following receipt thereof constitutes Facility's acceptance of such Material Change. In the event that Facility reasonably believes that a Material Change is likely to have a material adverse financial impact upon Facility, Facility agrees to notify Company in writing, specifying the specific bases demonstrating a likely material adverse financial impact, and the Parties will negotiate in good faith an appropriate amendment, if any, to this Agreement. Notwithstanding the foregoing, at Company's discretion, Company may modify the Policies to comply with applicable law or regulation, or any order or directive of any governmental agency, without the consent of Facility, and the Policies shall be deemed to be automatically amended to conform with all laws and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over this Agreement. Facility agrees that noncompliance with any requirements of this Section 5.1 or any Policies will relieve Company or Government Sponsors and Members from any financial liability for the applicable portion of the Facility Services.

5.2 Notices and Reporting.

To the extent neither prohibited by law nor violative of applicable privilege, Facility agrees to provide notice to Company, and shall provide all information reasonably requested by Company regarding the nature, circumstances, and disposition, of: (a) any action taken by Facility adversely affecting medical staff membership of Participating Physicians and other Participating Providers, whether or not such actions are reportable to NPDB or HIPDB; (b) any litigation or administrative action brought against Facility or any of its employees, medical staff members or affiliated providers which is related to the provision of health care services and could have a material impact on the Facility Services provided to Members; (c) any investigation initiated by The Joint Commission, another accrediting agency recognized by Company or any government agency or program against or involving Facility or any of its employees, medical staff members or affiliated providers that does or could adversely affect Facility's accreditation status, licensure, or certification to participate in the Medicare or Medicaid programs; (d) any change in the ownership or management of Facility; and (e) any material change in services provided by Facility or licensure status related to such services, including without limitation a significant decrease in medical staff or the closure of a service unit or material decrease in beds. Company and Facility agree to be mutually committed to promoting Member safety and quality. Therefore, Facility will report the occurrence of and waive all charges related to those conditions specified under Section 5001(c) of the Deficit Reduction Act, Section 2702 of the Affordable Care Act and any related or similar federal or state regulation, in accordance with the terms thereof. Facility agrees to use best efforts to provide Company with prior notice of, and in any event will provide notice as soon as reasonably practicable notice of, any actions taken by Facility described in this Section 5.2.

5.3 Information and Records.

5.3.1 Maintenance of Information and Records. Facility agrees (a) to maintain Information and Records (as such terms are defined in Section 5.3.2) in a current, detailed, organized and comprehensive manner and in accordance with customary medical practice, Government Sponsor directives, applicable Federal and state laws, and accreditation standards; (b) that all Member medical records and Confidential Information shall be treated as confidential and in accordance with applicable laws; (c) to maintain such Information and Records for the longer of six (6) years after the last date Facility Services were provided to Member, or the period required by applicable law or Government Sponsor directives; and (d) to maintain Information and Records in accordance with the requirements of Exhibits A and D, as applicable. This Section 5.3.1 shall survive the termination of this Agreement, regardless of the cause of the termination.

5.3.2 Access to Information and Records. Facility agrees that (a) Company (including Company's authorized designee) and Government Sponsors shall have access to all data and information obtained,

created or collected by Facility related to Members and necessary for payment of claims, including without limitation Confidential Information ("Information"); (b) Company (including Company's authorized designee), Government Sponsors and Federal, state, and local governmental authorities and their agents having jurisdiction, upon request, shall have access to all books, records and other papers (including, but not limited to, contracts, medical and financial records, and physician incentive plan information) and information relating to this Agreement and to those services rendered by Facility to Members ("Records"); (c) consistent with the consents and authorizations required by Section 2.5 hereof, Company or its agents or designees shall have access to medical records for the purpose of assessing quality of care, conducting medical evaluations and audits, and performing utilization management functions; (d) applicable Federal and state authorities and their agents shall have access to medical records for assessing the quality of care or investigating Member grievances or complaints; and (e) Members shall have access to their health information as required by 45 C.F.R. § 164.524 and applicable state law, be provided with an accounting of disclosures of information when and as required by 45 C.F.R. § 164.528 and applicable state law, and have the opportunity to amend or correct the information as required by 45 C.F.R. § 164.526 and applicable state law. Facility agrees to supply copies of Information and Records within fourteen (14) days of the receipt of a request, where practicable, and in no event later than the date required by Government Sponsor directives and any applicable law or regulatory authority. This Section 5.3.2 shall survive the termination of this Agreement, regardless of the cause of termination.

5.3.3 Government Requirements Regarding Records for Medicare Members. In addition to the requirements of Sections 5.3.1 and 5.3.2, with respect to Medicare Plans, Facility agrees to maintain Information and Records (as those terms are defined in Section 5.3) for the longer of: (i) ten (10) years from the end of the final contract period of any government contract of Company, (ii) the date the U.S. Department of Health and Human Services ("HHS"), the U.S. Comptroller General, or their designees complete an audit, or (iii) the period required by applicable laws, rules or regulations. Facility further agrees that, with respect to Medicare Plans, Company and Federal, state and local government authorities having jurisdiction, or their designees, upon request, shall have access to all Information and Records, and that this right of inspection, evaluation and audit of Information and Records shall continue for the longer of (i) ten (10) years from the end of the final contract period of any government contract of Company, (ii) the date HHS, the U.S. Comptroller General, or their designee complete an audit, or (iii) the period required by applicable laws, rules or regulations. This Section 5.3.3 shall survive the termination of this Agreement, regardless of the cause of termination.

5.4 Quality, Accreditation and Review Activities.
Facility agrees to cooperate with any Company quality activities or review of Company or a Plan conducted by the National Committee for Quality Assurance (NCQA) or a state or Federal agency with authority over Company and/or the Plan, as applicable.

5.5 Proprietary Information.

5.5.1 Rights and Responsibilities. Each Party agrees that the Proprietary Information of the other Party is the exclusive property of such Party and that each Party has no right, title or interest in the same. Each Party agrees to keep the Proprietary Information and this Agreement strictly confidential and agrees not to disclose any Proprietary Information or the contents of this Agreement to any third party without the other Party's consent, except (i) to governmental authorities having jurisdiction, (ii) in the case of Company's disclosure to Members, Government Sponsors, consultants and vendors under contract with Company, and (iii) in the case of Facility's disclosure to Members for the limited purpose of advising Members of potential treatment options and costs consistent with applicable Federal and state laws. Except as otherwise required under applicable Federal or state law, each Party agrees to not use any Proprietary Information of the other Party, and at the request of the other Party hereto, return any Proprietary Information upon termination of this Agreement for whatever reason. Notwithstanding the foregoing, Facility through its staff is encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which the Facility is paid. In addition, Facility through its staff may freely communicate with patients about their treatment

options, regardless of benefit coverage limitations. This Section 5.5.1 shall survive the termination of this Agreement for one (1) year, regardless of the cause of termination.

6.0 TERM AND TERMINATION

6.1 Term.
This Agreement shall be effective for an initial term ("Initial Term") of one (1) year from the Effective Date, and thereafter shall automatically renew for additional terms of one (1) year each, unless and until terminated in accordance with this Article 6.0.

6.2 Termination without Cause.
This Agreement may be terminated by Company at any time without cause with at least ninety (90) days prior written notice to Facility. This Agreement may be terminated by Facility without cause at any time following the conclusion of the Initial Term with at least ninety (90) days prior written notice to Company.

6.3 Termination for Breach.
This Agreement may be terminated at any time by either Party upon at least thirty (30) days prior written notice of such termination to the other Party upon material default or substantial breach by such Party of one or more of its obligations hereunder, unless such material default or substantial breach is cured within thirty (30) days of the notice of termination; provided, however, if such material default or substantial breach is incapable of being cured within such thirty (30) day period, any termination pursuant to this Section 6.3 will be ineffective for the period reasonably necessary to cure such breach if the breaching party has taken all steps reasonably capable of being performed within such thirty (30) day period. Notwithstanding the foregoing, the effective date of such termination may be extended pursuant to Section 6.6 herein.

6.4 Immediate Termination or Suspension.
Any of the following events shall result in the immediate termination or suspension of this Agreement by Company, upon notice to Facility, at Company's discretion at any time: (a) the withdrawal, expiration or non-renewal of any Federal, state or local license, certificate, approval or authorization of Facility; (b) the bankruptcy or receivership of Facility, or an assignment by Facility for the benefit of creditors; (c) the loss or material limitation of Facility's insurance under Section 2.5 of this Agreement; (d) a determination by Company that Facility's continued participation in provider networks could result in harm to Members; (e) the exclusion, debarment or suspension of Facility from participation in any governmental sponsored program, including, but not limited to, Government Programs, Medicare or the Medicaid program in any state; (f) the indictment or conviction of Facility for any crime; (g) the revocation or suspension of Facility's accreditation by The Joint Commissioner any other applicable accrediting agency recognized by Company; (h) the listing of Facility in the HIPDB; (i) change of control of Facility to an entity not acceptable to Company; or (j) the withdrawal, expiration or termination of the State Contract. To protect the interests of patients, including Members, Facility will provide immediate notice to Company of any of the aforesaid events described in clauses (a) through (i), including notification of impending bankruptcy.

6.5 Obligations Following Termination.
Following the effective date of any expiration or termination of this Agreement or any Plan, Facility and Company will cooperate as provided in this Section 6.5 and in Exhibits A and D, as applicable. This Section 6.5 and Exhibits A and D, as applicable, shall survive the termination of this Agreement, regardless of the cause of termination.

6.5.1 Upon Termination. Upon expiration or termination of this Agreement for any reason, other than termination by Company in accordance with Section 6.4 above, Facility agrees to provide Facility Services at Company's discretion to: (a) any Member who is an inpatient at Facility as of the effective date of termination until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) any Member, upon request of such Member or the applicable Plan Sponsor, for one (1) calendar year. The terms of this Agreement, including the **Services and Compensation Schedule** shall apply to all services under this Section 6.5.1.

6.5.2 Upon Insolvency or Cessation of Operations. If this Agreement terminates as a result of insolvency or cessation of operations of Company, and as to Members of HMOs that become insolvent or cease operations, then in addition to other obligations set forth in this section, Facility shall continue to provide Facility Services to: (a) all Members for the period for which premium has been paid; and (b) Members confined as inpatients in Facility on the date of insolvency or other cessation of operations until medically appropriate discharge. This provision shall be construed to be for the benefit of Members. No modification of this provision shall be effective without the prior written approval of the applicable regulatory agencies.

6.5.3 Obligation to Cooperate. Upon notice of expiration or termination of this Agreement or of a Plan, Facility shall cooperate with Company and comply with Policies, if any, in the transfer of Members to other providers.

6.6 Obligations During Dispute Resolution Proceedings.
In the event of any dispute between the Parties in which a Party has provided notice of termination under Section 6.3 and the dispute is required to be resolved or is submitted for resolution under Article 8.0 below, the termination of this Agreement shall be stayed and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

7.0 RELATIONSHIP OF THE PARTIES

7.1 Independent Contractor Status.
The relationship between Company and Facility, as well as their respective employees and agents, is that of independent contractors, and neither shall be considered an agent or representative of the other Party for any purpose, nor shall either hold itself out to be an agent or representative of the other for any purpose. Company and Facility will each be solely liable for its own activities and those of its agents and employees, and neither Company nor Facility will be liable in any way for the activities of the other Party or the other Party's agents or employees arising out of or in connection with: (a) any failure to perform any of the agreements, terms, covenants or conditions of this Agreement; (b) any negligent act or omission or other misconduct; (c) the failure to comply with any applicable laws, rules or regulations; or (d) any accident, injury or damage. Facility acknowledges that all Member care and related decisions are the responsibility of Facility and its medical staff, and that Policies do not dictate or control Facility's clinical decisions with respect to the care of Members. Facility agrees to indemnify and hold harmless the Government Sponsor and Company from any and all claims, liabilities and third party causes of action arising out of the Facility's provision of care to Members. Company agrees to indemnify and hold harmless the Facility from any and all claims, liabilities and third party causes of action arising out of the Company's administration of health care services in connection with the Plans. This provision shall survive the expiration or termination of this Agreement, regardless of the reason for termination.

7.2 Use of Name.
Facility consents to the use of Facility's name and other identifying and descriptive material in provider directories and in other materials and marketing literature of Company in all formats, including, but not limited to, electronic media. Facility may use Company's names, logos, trademarks or service marks in marketing materials or otherwise, upon receipt of Company's prior written consent, which shall not be unreasonably withheld.

7.3 Interference with Contractual Relations.
Facility shall not engage in activities that will cause Company to lose existing or potential Members, including but not limited to: (a) advising Company customers, Government Sponsors or other entities currently under contract with Company to cancel, or not renew said contracts; (b) impeding or otherwise interfering with negotiations which Company is conducting for the provision of health benefits or Plans; or (c) using or disclosing to any third party membership lists acquired during the term of this Agreement for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Notwithstanding the foregoing, Company shall not prohibit, or otherwise restrict, Facility from advising or advocating on behalf of a Member who is its patient, for the following: (i) the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; (ii) any

information the Member needs in order to decide among all relevant treatment options; (iii) the risks, benefits, and consequences of treatment or nontreatment; and (iv) the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. This section shall continue to be in effect for a period of one (1) year after the expiration or termination of this Agreement.

8.0 DISPUTE RESOLUTION

8.1 Member Grievance Dispute Resolution.
Facility agrees to (a) cooperate with and participate in Company's applicable appeal, grievance and external review procedures (including, but not limited to, Medicaid appeals and expedited appeals procedures), (b) provide Company with the information necessary to resolve same, and (c) abide by decisions of the applicable appeals, grievance and review committees. Company will make available to Facility information concerning the Member appeal, grievance and external review procedures at the time of entering into this Agreement.

8.2 Facility Dispute Resolution.
Company shall provide a mechanism whereby Facility may raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Facility shall exhaust this mechanism prior to instituting any arbitration or other permitted legal proceeding. The Parties agree that any dispute that may arise between the Parties shall not disrupt or interfere with the provision of services to Members. Discussions and negotiations held pursuant to this Section 8.2 shall be treated as inadmissible compromise and settlement negotiations for purposes of applicable rules of evidence.

8.3 Arbitration.

8.3.1 Submission of Claim or Controversy to Arbitration. Any controversy or claim arising out of or relating to this Agreement or the breach, termination, or validity thereof, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration administered by the American Arbitration Association ("AAA") and conducted by a sole Arbitrator ("Arbitrator") in accordance with the AAA's Commercial Arbitration Rules ("Rules"). The arbitration shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16, to the exclusion of state laws inconsistent therewith or that would produce a different result, and judgment on the award rendered by the Arbitrator (the "Award") may be entered by any court having jurisdiction thereof. A stenographic record shall be made of all testimony in any arbitration in which any disclosed claim or counterclaim exceeds $250,000. An Award for $250,000 or more shall be accompanied by a short statement of the reasoning on which the Award rests.

8.3.2 Appeal of Arbitration Award. In the event a Party believes there is a clear error of law and within thirty (30) days of receipt of an Award of $250,000 or more (which shall not be binding if an appeal is taken), a Party may notify the AAA of its intention to appeal the Award to a second Arbitrator (the "Appeal Arbitrator"), designated in the same manner as the Arbitrator except that the Appeal Arbitrator must have at least twenty (20) years' experience in the active practice of law or as a judge. The Award, as confirmed, modified or replaced by the Appeal Arbitrator, shall be final and binding, and judgment thereon may be entered by any court having jurisdiction thereof. No other arbitration appeals may be made.

8.3.3 Confidentiality. Except as may be required by law or to the extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an Award, neither a Party nor an arbitrator may disclose the existence, content, record, status or results of a negotiation or arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to a negotiation or arbitration, or reflecting the existence, content, record, status, or results of a negotiation ("Negotiation Record") or arbitration ("Arbitration Record"), is confidential. The arbitration hearing shall be closed to any person or entity other than the arbitrator, the parties, witnesses during their testimony, and attorneys of record. Upon the request of a Party, an arbitrator may take such actions as are necessary to enforce this Section 8.3.3, including the imposition of

sanctions.

8.3.4 Pre-hearing Procedure for Arbitration. The Parties will cooperate in good faith in the voluntary, prompt and informal exchange of all documents and information (that are neither privileged nor proprietary) relevant to the dispute or claim, all documents in their possession or control on which they rely in support of their positions or which they intend to introduce as exhibits at the hearing, the identities of all individuals with knowledge about the dispute or claim and a brief description of such knowledge, and the identities, qualifications and anticipated testimony of all experts who may be called upon to testify or whose report may be introduced at the hearing. The Parties and Arbitrator will make commercially reasonable efforts to conclude the document and information exchange process within sixty (60) calendar days after all pleadings or notices of claims have been received. At the request of a Party in any arbitration in which any disclosed claim or counterclaim exceeds $250,000, the Arbitrator may also order pre-hearing discovery by deposition upon good cause shown. Such depositions shall be limited to a maximum of three (3) per Party and shall be limited to a maximum of six (6) hours' duration each. As they become aware of new documents or information (including experts who may be called upon to testify), all Parties remain under a continuing obligation to provide relevant, non-privileged documents, to supplement their identification of witnesses and experts, and to honor any understandings between the Parties regarding documents or information to be exchanged. Documents that have not been previously exchanged, or witnesses and experts not previously identified, will not be considered by the Arbitrator at the hearing. Fourteen (14) calendar days before the hearing, the Parties will exchange and provide to the Arbitrator (a) a list of witnesses they intend to call (including any experts) with a short description of the anticipated direct testimony of each witness and an estimate of the length thereof, and (b) premarked copies of all exhibits they intend to use at the hearing.

8.3.5 Arbitration Award. The arbitrator may award only monetary relief and is not empowered to award damages other than as set forth in this Agreement. The Award shall be in satisfaction of all claims by all Parties. Arbitrator fees and expenses shall be borne equally by the Parties. Postponement and cancellation fees and expenses shall be borne by the Party causing the postponement or cancellation. Fees and expenses incurred by a Party in successfully enforcing an Award shall be borne by the other Party. Except as otherwise provided in this Agreement, each Party shall bear all other fees and expenses it incurs, including all filing, witness, expert witness, transcript, and attorneys' fees.

8.3.6 Survival. The provisions of Section 8.3 shall survive expiration or termination of this Agreement, regardless of the cause giving rise hereto.

8.4 Arbitration Solely Between Parties; No Consolidation or Class Action.
Company and Facility agree that any arbitration or other proceeding related to a dispute arising under this Agreement shall be conducted solely between them. Neither Party shall request, nor consent to any request, that their dispute be joined or consolidated for any purpose, including without limitation any class action or similar procedural device, with any other proceeding between such Party and any third party.

9.0 MISCELLANEOUS

9.1 Amendments.
This Agreement constitutes the entire understanding of the Parties hereto and no changes, amendments or alterations shall be effective unless signed by both Parties, except as expressly provided herein. Company may amend this Agreement upon thirty (30) days prior written notice, by letter, newsletter, electronic mail or other media (an "Amendment"). Failure by Facility to object in writing to any such Amendment within thirty (30) days following receipt thereof constitutes Facility's acceptance of such Amendment. In the event that Facility reasonably believes that an Amendment is likely to have a material adverse impact upon Facility, Facility agrees to notify Company in writing, specifying the specific bases demonstrating a likely material adverse impact, and the Parties will negotiate in good faith an appropriate revised Amendment, if any, to this Agreement. Notwithstanding the foregoing, at Company's discretion, Company may amend this Agreement to comply with applicable law or regulation, or any order or directive of any governmental agency, without the consent of Facility, and this Agreement shall be deemed to be automatically amended to conform with all

laws and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over this Agreement. Facility agrees that noncompliance with any requirements of this Section 9.1 will relieve Company or Government Sponsors and Members from any financial liability for the applicable portion of the Facility Services. Changes to Policies are addressed by Section 5.1 hereto.

9.2 Waiver.
The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, all waivers must be in writing and signed by an authorized officer of the Party to be charged. Facility waives any claims or cause of action for fraud in the inducement or execution related hereto.

9.3 Governing Law.
This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State of Iowa.

9.4 Liability.
Notwithstanding Section 9.3, either Party's liability, if any, for damages to the other Party for any cause whatsoever arising out of or related to this Agreement, and regardless of the form of the action, shall be limited to the damaged Party's actual damages. Neither Party shall be liable for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whatsoever sustained as a result of a breach of this Agreement or any action, inaction, alleged tortious conduct, or delay by the other Party.

9.5 Severability.
Any determination that any provision of this Agreement or any application thereof is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Neither Party shall assert or claim that this Agreement or any provision hereof is void or voidable if such Party performs under this Agreement without prompt and timely written objection.

9.6 Successors; Assignment.
This Agreement relates solely to the provision of Facility Services by Facility and does not apply to any other organization which succeeds to Facility assets, by merger, acquisition or otherwise, or is an affiliate of Facility. Neither Party may assign its rights or its duties and obligations under this Agreement without the prior written consent of the other Party, which consent may not be unreasonably withheld; provided, however, that Company may assign its rights or its duties and obligations to an Affiliate or successor in interest so long as any such assignment or delegation will not have a material impact upon the rights, duties and obligations of Facility.

9.7 Headings.
The headings contained in this Agreement are included for purposes of convenience only, and shall not affect in any way the meaning or interpretation of any of the terms or provisions of this Agreement.

9.8 Notices.
Except for any notice required under Article 6, Term and Termination, or if otherwise specified, notices required pursuant to the terms and provisions hereof may be effective if sent by letter, electronic mail or other generally accepted media. With respect to notices required under Article 6, notice shall be effective only if given in writing and sent by overnight delivery service with proof of receipt, or by certified mail return receipt requested. Notices shall be sent to the addresses set forth on the signature page of this Agreement (which addresses may be changed by giving notice in conformity with this Section 9.8). Facility shall notify Company of any changes in the information provided by Facility related to Facility's address.

9.9 Remedies.
Notwithstanding Sections 8.3 and 9.4, the Parties agree that each has the right to seek any and all remedies at law or equity in the event of breach or threatened breach of Section(s) 5.5, 6.6 and 7.3.

9.10 Non-Exclusivity. This Agreement is not exclusive, and nothing herein shall preclude either Party from contracting with any other person or entity for any purpose. Company makes no representation or guarantee as to the number of Members who may select or be assigned to Facility.

9.11 Force Majeure.
If either Party shall be delayed or interrupted in the performance or completion of its obligations hereunder by any act, neglect or default of the other Party, or by an embargo, war, act of terror, riot, incendiary, fire, flood, earthquake, epidemic or other calamity, act of God or of the public enemy, governmental act (including, but not restricted to, any government priority, preference, requisition, allocation, interference, restraint or seizure, or the necessity of complying with any governmental order, directive, ruling or request) then the time of completion specified herein shall be extended for a period equivalent to the time lost as a result thereof. This Section 9.11 shall not apply to either Party's obligations to pay any amounts owing to the other Party, nor to any strike or labor dispute involving such Party or the other Party.

9.12 Confidentiality.
It is further understood and agreed by and among the Parties that the terms and conditions of this Agreement, except as otherwise specified, are and shall remain confidential, and shall not be disclosed by either Party without express written consent of the other Party or as required by law or by governmental authorities or by express order by a court having jurisdiction over the Party from whom disclosure is sought.

9.13 Entire Agreement.
This Agreement (including any attached schedules, appendices and/or addenda) constitutes the complete and sole contract between the Parties regarding the subject matter described above and supersedes any and all prior or contemporaneous oral or written representations, communications, proposals or agreements not expressly included in this Agreement and may not be contradicted or varied by evidence of prior, contemporaneous or subsequent oral representations, communications, proposals, agreements, prior course of dealings or discussions of the Parties. The Parties understand and agree that this Agreement only applies to the Plans described in this Agreement and, likewise, this Agreement does not and will not supersede any agreement(s) between Company's affiliates and Provider that relates to Company's affiliates other lines of business that are not the subject of this Agreement (that are not the Plans described in this Agreement).

9.14 Signatures. Facsimile and electronic signatures shall be deemed to be original signatures for all purposes of this Agreement.

9.15 Incorporation of Recitals. The Parties incorporate the recitals into this Agreement as representations of fact to each other.

The remainder of this page intentionally left blank. Signature page follows.

IN WITNESS WHEREOF, the undersigned parties have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.

Facility Sign Here

FACILITY

By:_____

Printed Name:_____

Title:_____

Date:_____

COMPANY

By:_____ _____

Printed Name:_____

Title:_____

Date:_____

REIMBURSEMENT ADDRESS:

_____
_____
_____

MAIN TELEPHONE NUMBER:_____

CHIEF EXECUTIVE OFFICER:_____

CHIEF FINANCIAL OFFICER:_____

BUSINESS OFFICE MANAGER:_____

FEDERAL TAX I.D. NUMBER:_____

NPI NUMBER:_____

As required by Section 9.8 ("Notices") of this Agreement, notices shall be sent to each Party at the following addresses:

To Facility at:
_____
_____
_____
_____

To Company at:

Aetna Better Health of Iowa
Attn: Network Management
4320 NW 114th Street
Urbandale, IA 50322

With a copy to:
Aetna
Law Dept, Medicaid, Mail Code RE6A
151 Farmington Avenue
Hartford, CT 06156-0001

PROGRAM PARTICIPATION SCHEDULE

Facility agrees to participate in the Plans and other health benefit programs listed herein upon issuance of any required licenses and contracts to Company:

Iowa Medicaid managed care Plans offered by Aetna Better Health of Iowa Inc., pursuant to contract with the Iowa Department of Human Services for delivery of high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa hawk-i programs.

SERVICES AND COMPENSATION SCHEDULE

1.0 COMPENSATION

Iowa Medicaid, CHIP & QHP Plans:	Aetna Medicaid Market Fee Schedule
Iowa Medicare Plans:	Medicare Allowable Rate

2.0 SERVICES

Provider will be reimbursed for those Covered Services in accordance with the terms of this Agreement that are within the scope of and appropriate to the Provider's license and certification to practice.

3.0 GENERAL COMPENSATION TERMS AND CONDITIONS

Definitions

"Aetna Medicaid Market Fee Schedule (AMMFS)" – A fee schedule that is based upon the contracted location where service is performed and the State ofIowa's Medicaid Fee Schedule.

"Medicare Allowable" - the current payment as of discharge date that a hospital will receive from Company, subject to the then current Medicare Inpatient Prospective Payments Systems and will be updated in accordance with CMS changes, provided, however, that exempt units for psychiatric, rehabilitation and skilled nursing facility services will be paid in accordance with the applicable Medicare Prospective Payment Systems. These payments are intended to mirror the payment a Medicare Fiscal Intermediary ("FI") would make to the hospital, less (with respect to DRG-based payments) the payments for Indirect Medical Education (IME), Direct Graduate Medical Education (DGME), bad debt, as appropriate and adjusted by CMS or Government Sponsor for sequestration, SGR or other items and Aetna payment and processing guidelines. For other provider types, the Medicare allowable rate is based upon CMS Geographic Pricing Cost Indices (GPCI) and Resource Based Relative Value Scale (RBRVS) Relative Value Units (RVU) including Outpatient Prospective Payment System (OPPS) cap rates; the Clinical Laboratory Fee Schedule (CLAB); the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule; including PEN (DMEPOS) and 'Medicare Part B Drug Average Sales Price (ASP),' as appropriate. Coding and fees determined under this schedule will be updated as CMS releases code updates, changes in the MFS relative values, including OPPS cap payments, or the CMS conversion factors. Company plans to update the schedule within 90 days of the final rates and/or codes being published by CMS. However, the rates and coding sets for these services do not become effective until updates are completed by Company and payment is considered final and exclusive of any retroactive or retrospective CMS adjustments to the rate. Company payment policies apply to services paid based upon the Medicare allowable rate.

General

A. Member Cost Share. Rates are inclusive of any applicable Member Copayment, Coinsurance or Deductible.

B. Billing. When billing, Provider must designate applicable codes related to those Covered Services provided by Provider under the terms of this Agreement.

C. Coding. Company utilizes nationally recognized coding structures including, but not limited to, Revenue Codes as described by the Uniform Billing Code, AMA Current Procedural Terminology (CPT4), CMS Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), ICD-9 (or successor standard) Diagnosis and Procedure codes, and National Drug Codes (NDC). As changes are made to nationally-recognized codes, Company will update internal systems to accommodate new codes. Such changes will only be made when there is no material change in the procedure itself. Until updates are complete, the procedure will be paid according to the standards and coding set for the prior period.

The use of ICD-10 coding shall not impact the aggregate rates and compensation intended by the Parties as set forth in this Services and Compensation Schedule. Consequently, in the event that use of ICD-10 codes result in aggregate payments that would differ from the aggregate payments that would have resulted based on ICD-9 coding (excluding utilization and validated case mix severity changes), the rates set forth in this Services and Compensation Schedule will be reviewed by Company periodically and adjusted at least annually in order to reflect what would have been paid had ICD-9 coding been utilized for determination of the payments.

Company will comply and utilize nationally recognized coding structures as directed under applicable Federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act (HIPAA).

D. Affordable Care Act Primary Care Enhancement. For those primary care Covered Services that the State of Iowa has determined to reimburse at 100% of the Medicare allowable amount in accordance with Section 1902(a)(13)(C) of the Social Security Act, for so long as the rates are in effect and so long as Facility meets the requirements of applicable law for the rates, Company shall compensate Facility for the provision of such Covered Services to eligible Members delivered in accordance with the terms and conditions set forth in this Agreement at the lesser of Facility's billed charges or an amount equal to but not greater than the State's enhanced rates. Facility certifies that, to the extent required by law, such payments will insure to the benefit of the individual Participating Physicians, and will supply Company with any legally-required documentation of such. Company reserves the right i) to pay such enhanced compensation through monthly or quarterly adjustment; ii) to make payments directly to qualifying Participating Physicians; and/or iii) to require such Physicians or Facility to complete any agreements, forms, attestations or releases needed to effectuate such payments. Enhanced compensation is not available for Members of CHIP Plans.

E. Medicare-Medicaid Dual-Eligibles – Where Company is the responsible payor for Medicare and Medicaid Covered Services, rates for each service are determined by whether that service is regarded as a Medicare Covered Service or a Medicaid Covered Service by CMS and Government Sponsor, and with respect to a Member's benefit limits under each program. For Medicare Covered Services (inclusive of Member Copayment or Coinsurance), Company shall compensate provider at the specified Medicare rate. For Medicaid Covered Services, Company shall compensate provider according to the applicable Medicaid rate. When a service is covered under Medicare and Medicaid, Company will determine the rate (Medicare or Medicaid) according to applicable law, coordination of benefit principles and the terms of Member's Plan. Rates do not include, and Company is not responsible for, supplemental or wrap-around payments unless required by Company's contracts with Government Sponsor.

Exhibit A

Iowa Regulatory Compliance Addendum

This Regulatory Compliance Addendum is incorporated by reference into the Agreement. It applies to Iowa Medicaid managed care plans offered by Better Health of Iowa Inc. ("Company"), pursuant to contract with the Iowa Department of Human Services (DHS) for delivery of high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa hawk-i programs and the eligible populations covered by the State Contract between Company and DHS. This Addendum is effective as of the Effective Date of the Agreement.

Provider agrees that all applicable terms and conditions set out in the RFP, the State Contract, any incorporated documents and all applicable state and federal laws, as amended, govern the duties and responsibilities of the Provider with regard to the provision of services to members in the programs applicable hereto. The RFP and State Contract may currently be found at: http://bidopportunities.iowa.gov/?pgname=viewrfp&rfp_id=11140

If there is any conflict between the terms of this Addendum and any of the other terms of the Agreement, including any attachments, schedules, exhibits and/or addenda made part of the Agreement, the terms of this Addendum will govern and control; provided, however, if there is any conflict between any of the terms of the Agreement, including this Addendum, and the State Contract, then the terms of the State Contract will govern and control. For purposes of this Regulatory Compliance Addendum, the term "Provider" shall mean the health care physician, provider, group, facility or hospital executing the Agreement, as identified on the first page of the Agreement.

1.0 DEFINITIONS [taken from the RFP Glossary]

When used in this Agreement, all capitalized terms shall have the following meanings:

Children's Health Insurance Program ("CHIP"). The program created in 1997 by Title XXI of the Social Security Act and known in Iowa as CHIP.

Claim. A formal request for payment for benefits received or services rendered.

CMS. The Centers for Medicare and Medicaid Services.

Co-Payment. A cost-sharing arrangement in which a Member pays a specified charge for a specified service; also called a co-pay.

Covered Services. Those health care services/benefits to which an individual eligible for Medicaid/CHIP is entitled under the Iowa Medicaid State Plan and which Company is required to provide or arrange for pursuant to the State Contract.

IDPH. Iowa Department of Public Health.

IDPH Participants. A resident of the State of Iowa with an income at or below 200% of the federal poverty guidelines as published by the Department of Health and Human Services who is not insured or for whom third party payment is not available to pay for services. An Iowa Medicaid member shall not be an IDPH Participant. An Iowa Health and Wellness Plan member may be an IDPH Participant for those IDPH-funded substance use disorder services that are not fully covered by the Iowa Health and Wellness Plan.

Iowa Department of Human Services ("DHS"). The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Iowa.

Iowa Medicaid State Plan. The binding written agreement between DHS and CMS, which describes how the Medicaid program is administered and determines the services for which DHS will receive federal financial participation.

Medicaid. A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act Amendment. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving covered individuals.

Medical Records. All medical, behavioral health, and long-term care histories; records, reports and summaries; diagnoses; prognoses; record of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, behavioral health, and long-term care documentation in written or electronic format; and analyses of such information.

Medically Necessary Services. Those Covered Services that are, under the terms and conditions of the State Contract, determined through Company utilization management to be:

(1) Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the Member;

(2) Provided for the diagnosis or direct care and treatment of the condition of the Member enabling the Member to make reasonable progress in treatment;

(3) Within standards of professional practice and given at the appropriate time and in the appropriate setting;

(4) Not primarily for the convenience of the Member, the Member's physician or other provider; and

(5) The most appropriate level of Covered Services, which can safely be provided.

Member. A Medicaid recipient who is subject to mandatory enrollment or is currently enrolled in Company's coverage under the State Contract.

Policies. In addition to the policies and procedures promulgated by Company, which relate to the duties and obligations of the Parties under the terms of the Agreement, Policies include the general principles by which DHS is guided in its management of the Title XIX program, as further set forth and defined by DHS promulgations and by state and federal rules and regulations.

Provider Preventable Conditions. Situations in which Medicaid payment is prohibited for services that should have been avoidable as defined in 42 CFR §447.26.

State Contract. The written agreement between Company and DHS, a copy of which may be found by Provider on the State's website. The State Contract is comprised of and incorporates all provisions of the RFP and any addenda, appendices, attachments or amendments thereto, as well as any Member handbook, provider handbook and/or other applicable policy guides, manuals and materials.

2.0 PROVIDER SERVICES AND OBLIGATIONS

2.1 Medical Necessity.
Provider agrees that for the purposes of Covered Services to Members, "Medically Necessary Services" shall be as defined above in this Addendum.

2.2 Timely Access.
Provider must meet the standards for timely access to care and services for Members as set forth on Exhibit B to the RFP, taking into account the urgency of the need for services. Provider must offer hours of operation to Members that are no less than the hours of operation offered to other non-Medicaid patients, or if Provider serves only Medicaid beneficiaries, hours of operation comparable to the hours of operation offered to enrollees of any Iowa Medicaid Fee for Service Program. Provider agrees to provide Covered Services to Members on a twenty-four (24) hour per day, seven (7) day per week basis. [42 CFR 438.209]

2.3 Inability To Pay Co-Payment.

Provider shall not deny care or services to any Member because of the Member's inability to pay the Co-Payment. [RFP SOW §5.3.5]

2.4 Medical Records.

Provider shall create and maintain Medical Records for Members in accordance with applicable law including, but not limited to, Iowa Administrative Code Title 441, Chapter 79.3 and Policies. Without limiting the foregoing, Provider's records must be maintained in a manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical Records must be legible, signed, dated and maintained as required by law. Provider shall provide a copy of the Member's Medical Record to the Member upon reasonable request by the Member at no charge. Provider shall facilitate the transfer of a Member's Medical Record to another provider at the Member's request. Provider must maintain the confidentiality of and access to Medical Records in accordance with the standards mandated in the Health Insurance Portability and Accountability Act and all other state and federal requirements. Provider shall permit Company, representatives of DHS, and other authorized entities to review Members' Medical Records for purpose of monitoring Provider's compliance with the record standards, capturing information for clinical studies, monitoring quality or any other reason. Without limiting the foregoing, Provider will release mental health information regarding Members only as allowed by Iowa Code §228. [RFP SOW §6.1.9 & 2.15]

2.5 Member Rights.

Provider shall take Members' rights as set forth in law into account when providing services to Members. Such rights include the right to receive information as set forth in 42 CFR §438.100, the right to be treated with respect and with due consideration for his or her dignity and privacy; the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand; the right to participate in decisions regarding his or her health care, including the right to refuse treatment; the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion; the right to treatment in the least restrictive setting; the right to fully participate in the community and to work, live and learn to the fullest extent possible; and the right to be furnished health care services in accordance with 42 CFR §§438.206 through 438.210. [RFP SOW §1.4.1]

2.6 Critical Incidents.

If Provider is a provider who has personal contact with Members under the Home-and-Community-Based Services (HCBS) habilitation and waiver services, Provider shall (i) report critical incidents; (ii) respond to critical incidents; (iii) document critical incidents; and (iv) cooperate with any investigation conducted by Company or an outside agency. Provider shall complete any critical incident training required by Company. [RFP SOW §10.4.2]

2.7 Enforcement of §6032 of the 2005 Deficit Reduction Act (DRA).

If Provider receives five million dollars ($5,000,000) or more in Medicaid payments in a federal fiscal year, Provider shall have written policies for all employees, including management, and for all employees of any contractor or agent, that provide detailed information about the following: [RFP SOW §12.12]

a. The Federal False Claims Act under title 31 of the United States Code, sections 3729 through 3733;

b. Administrative remedies for false claims and statements under title 31 of the United States Code, chapter 38;

c. Any State laws pertaining to civil or criminal penalties for false claims and statements (Iowa Code 249A.8 and 714.8(10)-714.14);

d. Whistleblower protections under such laws; and

e. The Provider's policies and procedures for detecting and preventing fraud, waste, and abuse.

2.8 Additional Duties For Nursing Facilities. If Provider is a nursing facility, Provider shall: [RFP SOW §6.1.2.1]

a. Promptly notify Company of a Member's admission or request for admission to the nursing facility as soon as the facility has knowledge of such admission or equest for admission;

b. Notify the Company immediately if the nursing facility is considering discharging a Member and to consult with the Member's care coordinator;

c. Notify the Member and/or the Member's representative (if applicable) in writing prior to discharge in accordance with state and federal requirements;

d. Collect from any Member the Member's patient liability amount as communicated to Provider by Company. Provider agrees that payments from Company to Provider will be net of the applicable patient liability amount for any Member with patient liability.

e. Notify Company of any change in a Member's medical or functional condition that could impact the Member's level of care eligibility for the currently authorized level of nursing facility services;

f. Comply with federal Preadmission Screening and Resident Review ("PASRR") requirements to provide or arrange to provide specialized services and all applicable Iowa law governing admission, transfer and discharge policies; and

g. hereby agrees that the Agreement will automatically be terminated in accordance with federal requirements if Provider is involuntarily decertified by the State or CMS.

2.9 Additional Duties for Home and Community-Based Services. If Provider provides Home and Community-Based Services, Provider shall: [RFP SOW §6.1.2.2]

a. Provide at least thirty (30) days advance notice to the Company when the Provider is no longer willing or able to provide services to a Member and to cooperate with the Member's care coordinator to facilitate a seamless transition to alternate providers;

b. In the event that a HCBS provider change is initiated for a Member, regardless of any other provision in Agreement, continue to provide services to the Member in accordance with the Member's plan of care until the Member has been transitioned to a new provider, as determined by the Company, or as otherwise directed by the Company, which may exceed thirty (30) days from the date of notice to the Company;

c. Immediately report any deviations from a Member's service schedule to the Member's care coordinator;

d. Comply with the critical incident reporting requirements.

e. Comply with all child and dependent adult abuse reporting requirements.

2.10 Additional Duties for Community-Based Services Providers For Resident Transfer and Discharge. Neither Company nor Provider shall transition nursing facility, ICF/ID, 1915(i) Habilitation or 1915(c) community-based residential alternative residents to another facility or residence unless: (i) the Member or

his/her representative specifically requests to transition; (ii) the Member or his/her representative provides written consent to transition based on quality or other concerns raised by the Company or Provider, which shall not include the residential provider's rate of reimbursement; or (iii) the provider has chosen not to contract with the Company. The Company shall establish contractual terms with its providers, subject to approval by DHS, that protects an individual from involuntary discharge that may lead to a placement in an inappropriate or more restrictive setting. The Company shall facilitate a seamless transition whenever a Member transitions between facilities or residences. [RFP SOW §4.3.10]

2.11 Additional Duties for Providers with IDPH Participants.
If Provider provides services to IPDH Participants who are intravenous ("IV") drug users, Provider shall perform outreach activities. Provider shall select, train and supervise outreach workers. Provider shall encourage individuals needing IV treatment to undergo treatment and provide awareness about the relationship between IV drug use and communicable disease. Provider shall use outreach models that are applicable to the local situation and use an approach that can be expected to be reasonably effective. [RFP SOW §3.2.8.15]

2.12 Additional Duties for IHH Providers.
If Provider provides integrated health homes services, Provider agrees to provide the following: (i) quality-driven, cost-effective, culturally appropriate, and person-and family-driven health home services; (ii) high-quality health care services informed by evidence-based clinical practice guidelines; (iii) preventive and health promotion services informed by evidence-based clinical practice guidelines; (iv) preventive and health promotion services, including prevention of mental illness and substance use disorders; (v) comprehensive care management, care coordination and transitional care across settings; (vi) chronic disease management, including self-management support to Members and their families; (vii) demonstrating a capacity to use health information technology to link services, facilitate communication among team members and between the health home team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and (viii) establishing a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level. [RFP SOW §3.2.9.1.2]

3.0 CLAIMS SUBMISSION, COMPENSATION AND MEMBER BILLING

3.1 Timely Filing.
Provider shall submit all Claims that do not involve a third party payer, to Company within ninety (90) days of the date of service. [RFP SOW §6.1.2]

3.2 Cost Sharing and Patient Liability.
Provider shall not require any cost sharing or patient liability responsibilities for Covered Services except to the extent that cost sharing or patient liabilities are required for those services in accordance with law and the Agreement. [RFP SOW §3.2.15.3]

3.3 Third Party Liability.
Provider shall identify any third party liability coverage available to a Member, including Medicare and long-term care insurance, as applicable, and except as otherwise required, seek such third party liability payment before submitting Claims to Company. [RFP SOW §6.1.2]

3.4 Payment Net of Co-Payment.
Provider acknowledges and agrees that Company shall reduce the amount of payment it makes to Provider by the amount of the Member's Co-Payment obligation regardless of whether Provider has collected or waived the Co-Payment, except as provided in 42 C.F.R. §447.56(c). [RFP SOW §5.3.6]

3.5 Missed Appointments.
Provider shall not charge Members for missed appointments. [RFP SOW §3.2.15.3]

3.6 IDPH Participant Substance Use Disorder Services.

If and to the extent Provider provides substance use disorder services to IDPH Participants, Provider agrees to accept payment from the IDPH Participant according to the IDPH-approved siding fee schedule for such substance use disorder services. Providers billing and collection procedures for IDPH Participants shall be consistent with those established and provided by the IDPH. Provider agrees that services funded partially or completely by IDPH shall not be denied to a person because of the inability of the person or group to pay a fee for the service. Further, Provider shall not charge and IDPH Participant for missed appointments; provided, however, that Provider may charge the IDPH Participant a one-time no-show fee in an amount not to exceed that established by the IDPH. Provider acknowledges and agrees that IDPH funds are the payment of last resort for substance use disorder services provided to IDPH Participants and shall comply with IDPH and Company policies on IDPH eligibility for person with insurance coverage. [RFP SOW §5.5 & 13.6.4]

3.7 Provider Preventable Conditions.

Provider acknowledges and agrees that Company shall not make payment to Provider for a Provider Preventable Condition. This includes health-acquired conditions as identified by Medicare other than deep vein thrombosis and pulmonary embolism following total knee replacement or hip replacement surgery in pediatric and obstetric patients. Company shall also not make payment for wrong surgical or other invasive procedure on a patient or surgical, other invasive procedure performed on the wrong body part or wrong patient or any future additional to the list of non-reimbursable Provider Preventable Conditions. As a condition of payment under the Agreement, Provider agrees to comply with the reporting requirements for Provider Preventable Conditions found at 42 CFR §447.26(d). [RFP SOW §10.5]

4.0 GENERAL PROVISIONS

4.1 Debarred Individuals.

Provider represents and warrants that Provider is not and at no time has been (i) a person debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or (ii) an affiliate, as defined in the Federal Acquisition Regulation, of a person described in subsection (i) above. Provider shall immediately notify Company if at any time this representation and warranty is no longer accurate. [RFP SOW §2.6]

Exhibit D

Medicare Compliance Addendum

Without limiting any obligation of Provider under the Agreement, Provider agrees to the requirements set forth in this Addendum. Capitalized terms not otherwise defined herein, including within Schedule 1 attached hereto, shall have the meanings ascribed to them in the Agreement.

1. DESCRIPTION. This Addendum includes any Medicare plan(s) offered by Company to Medicare beneficiaries under a contract with the Centers for Medicare and Medicaid Services pursuant to Part C of Title XVIII of the Social Security Act ("Medicare Plans"). The Medicare Plans included in this Addendum do NOT include any Medicare Advantage plan(s) that the Company has deemed to be Medicare High Performance Network plans. From time to time Company and/or Payers may designate only certain Participating Providers to take part in the provider delivery network for a particular Product benefit plan(s).

2. PAYMENT.
A. In consideration of Provider's agreement to perform Covered Services in accordance with the Agreement, Provider shall be paid for Covered Services performed according to the terms of the applicable Service and Rate Schedule.

B. Company shall not pay any amounts beyond the amounts set forth in the applicable Service & Rate Schedule, including but not limited to any incentive payments that may be payable under traditional Medicare, except as expressly required by the Agreement or applicable law. Further, the Parties acknowledge and agree that payments under the Medicare program to providers, suppliers, and Medicare Advantage organizations may be adjusted as the result of legislation, regulation, executive order or other federal mandate ("Medicare Payment Adjustment"). Furthermore, any such Medicare Payment Adjustment could result in an increase or decrease in Medicare payments. In accordance with the terms of this Agreement, the Parties agree that, in the event of a Medicare Payment Adjustment, Company's payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. Company shall adjust payments under this Agreement for Covered Services rendered by Provider on and after the effective date of the Medicare Payment Adjustment, and shall continue to adjustment payments to Provider for until the earlier of (i) the Medicare Payment Adjustment is discontinued or (ii) is replaced by a subsequent Medicare Payment Adjustment.

C. Pursuant to Section 6.K. of this Addendum, Provider certifies that the diagnosis codes submitted to Company for Medicare Members that Company is required to submit to CMS will be accurate, complete and truthful ("Certification"). Provider acknowledges and agrees that Company may impose a penalty on Provider not to exceed five thousand dollars ($5,000) for each instance that Provider submits a diagnosis code to Company for a Medicare Member that does not comply with this Certification because the diagnosis code was not submitted in the format described in 42 C.F.R. § 422.310 or any subsequent or additional federal regulations. For purposes of this Section 2, "diagnosis code" shall mean an International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) code or its successor.

D. Federal laws and regulations limit the timeframe within which CMS may recover overpayments made to physicians, providers, and suppliers who submit claims to Medicare contractors (such as fiscal intermediaries, regional home health intermediaries, carriers, Medicare Administrative Contractors, and Durable Medical Equipment Medicare Administrative Contractors) for services provided or supplied to Medicare beneficiaries enrolled in Original Medicare ("Medicare Statute of Limitations"). If Company makes an overpayment or payment in error to Provider for Medicare Members, Company shall have the right to initiate overpayment recovery efforts within the same timeframe available to CMS under the Medicare Statute of Limitations; provided that no time limit shall apply to initiation of overpayment recovery efforts based on Company's reasonable suspicion of fraud or other intentional misconduct.

3. ASSIGNMENT. In addition to all other rights of Company under the Agreement, the Agreement (including, but not limited to, as it relates to the line(s) of business described in this Addendum) may be assigned by Company, at any time and from time to time, in whole or in part, to any other affiliate or successor in interest. At Company's option, the Agreement shall survive, without any other change in its terms, as a distinct, separate agreement with

Company for those products/lines of business designated by Company and in duplicate form as a separate, distinct participating provider agreement with the applicable affiliate(s)/successor(s) for the products/lines of business assigned to such entity(ies). In the event of any assignment under this paragraph, Company shall provide advance written notice to Provider. In the event of a conflict between this paragraph and any other provision of the Agreement, the terms of this paragraph shall supersede and prevail.

4. EFFECT OF TERMINATION. In the event this Addendum is terminated for any reason, such termination shall not constitute termination of any of Company's other products, plans or programs.

5. MEDICARE REQUIRED PROVISIONS. Provider agrees to comply with all of the provisions of Schedule 1, attached hereto and incorporated into this Addendum.

6. PROVIDER OBLIGATIONS.
A. Provision of Covered Services. Provider agrees to provide to Medicare Members the health care services for which Provider is licensed and customarily provides in accordance with accepted medical and surgical standards in the community. Provider shall make Covered Services available and accessible to Medicare Members, including telephone access to Provider, on a twenty-four (24) hours, seven (7) days per week basis.

B. Provider agrees that all Medicare Services and other activities performed by Provider under the Agreement will be consistent and comply with Company's obligations as a Medicare Advantage Organization under Company's contracts with CMS. Upon request, Provider shall immediately provide to Company any information that is required by Company to meet its reporting obligations to CMS, including without limitation, physician incentive plan information, if applicable. To the extent that Provider generates and/or compiles and provides any data to Company that Company, in turn, submits to CMS, Provider certifies, to the best of its knowledge and belief, that such data is accurate, complete and truthful. Provider agrees to cooperate with and participate in internal and external review procedures necessary to allow Company to process Medicare appeals and grievances in accordance with Medicare laws, regulations and CMS instructions.

C. Federal Fund Obligations. Provider understands and agrees that payments received by Company for the Medicare Plans from CMS pursuant to the Medicare Plan's contract with CMS are Federal funds. As a result, Provider, by entering into this Agreement and the terms of this Addendum, is subject to laws applicable to individuals/entities receiving Federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R. part 84, the Age Discrimination Act of 1975 as implemented by regulations at 45 C.F.R. part 91, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

D. Continuation of Services. In the event Company's Medicare contract for the Medicare Plans with CMS terminates or Company becomes insolvent, Provider shall continue to provide Covered Services to Medicare Members who are hospitalized through the later of: (a) the date for which premiums were paid, or (b) through the date of discharge. Provider is prohibited by law from billing Medicare Members for such Covered Services. This provision shall survive the termination of this Agreement or Addendum, regardless of the reason for termination, including the insolvency of Company, and shall supersede any oral or written agreement between Provider and a Medicare Member.

E. Policies, Programs & Procedures. Provider agrees to comply with Company's policies and procedures (which Company shall provide to Provider upon request) which operationalize many of the requirements of the Agreement, this Addendum, and the Medicare Program. Provider agrees to comply with Company's quality improvement, administrative processes and procedures, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures, and any other policies Company may implement, including amendments made to the above mentioned policies, procedures and programs from time to time. In the event that a Company policy or procedure conflicts with a provision in the Agreement, then the language in the Agreement (including all amendments, exhibits, and attachments thereto) shall govern.

F. Maintenance of Records. Provider shall preserve records applicable to Medicare Members or to Company's participation in the Medicare Program, for the longer of: (i) the period of time required by State and Federal law, or (ii) ten (10) years, whichever is longer. In addition, to the extent applicable to Provider, Provider, on behalf of itself and any Downstream Entities with whom Provider has contracted, agrees to comply with 42 C.F.R. §422.2480(c)

and to maintain all records containing data used by Company to calculate Medicare medical loss ratios ("MLRs") for Company's Medicare Products and/or evidence needed by Company and/or federal governmental authorities with jurisdiction to validate MLRs (collectively, "MLR Records") for a minimum of ten (10) years from the date such MLRs were reported by Company to CMS.

G. Subcontractors. Provider shall require all of its subcontractors, if any, to comply with all applicable Medicare laws, regulations and CMS instructions.

(1) Provider shall include in Provider's contracts with subcontractors all of the contractual and legal obligations required by Company or the laws, regulations, rules and directions of CMS, including, without limitation, that any delegated services or activities to be performed by subcontractor shall be consistent and comply with the obligations in the contract between CMS and Company governing Company's participation in the Medicare Program. To the extent CMS requires additional provisions to be included in such subcontracts, Provider shall amend its contracts accordingly.

(2) Provider shall ensure that any vendors, subcontractors or other such entities that have a need to know the terms of the Agreement also maintain the privacy and confidentiality of all financial terms of the Agreement.

(3) If Provider arranges for the provision of Covered Services from other health care providers for Medicare Members, such contracts shall be in writing and shall specify the delegated activities and reporting responsibilities, in addition to meeting the requirements described above. In the event that Company delegates to Provider the selection of providers, Company retains the right to approve, suspend or terminate such delegation. If Company delegates the selection of providers, Company will either review the credentials of medical professionals affiliated with Provider or Company will review, approve, and audit on an ongoing basis Provider's credentialing process. The term "Subcontractor" as used in this Section shall not refer to employees or other individuals that perform services on behalf of Provider for which Provider bills such services under this Agreement. Provider represents and warrants that such persons are subject to all terms and conditions of this Agreement and Provider shall provide written evidence of such as described in the Agreement.

H. Contracts with Excluded Entities. Provider understands and agrees that no person that provides health care services under this Agreement, or persons that provide utilization review, medical social work or administrative services in support of services billed under this Agreement by Provider may be an individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. Provider hereby certifies that no such excluded person will provide such services under this Agreement and no such excluded persons will be employed by or utilized by any Downstream Entity with which Provider contracts relating to the furnishing of these services to Medicare Members. In accordance with applicable laws, rules and regulations and the Compliance Program Guidelines, Provider agrees to review the Department of Health and Human Services ("HHS") Office of Inspector General List of Excluded Individuals and Entities and the General Service Administrative Excluded Parties Lists System (collectively, "Exclusion Lists") to ensure that Provider Related Parties are not included on such Exclusion Lists. Provider agrees to review the Exclusion Lists prior to initially hiring, appointing or contracting with any new Provider Related Party and at least once per month thereafter to confirm that Provider Related Parties are not included on such Exclusion Lists. Provider agrees that if a Provider Related Party appears on an Exclusion List and/or is excluded from participation in any federally-funded health program, Provider will immediately remove the Provider Related Party from any work related directly or indirectly to Company's Medicare Plans, and take all corrective actions required under applicable laws, rules or regulations. In the event Provider or any Provider Related Parties are listed in an Exclusion List after the Effective Date of this Addendum, Company shall have the right, in its sole discretion and judgment, to terminate this Addendum in accordance with the Agreement or to disqualify the listed person(s) from providing any part of the Covered Services. For the purpose of this section "Provider Related Parties" means Provider's permanent and temporary employees and Downstream Entities that are involved in the performance of Medicare Services.

I. Offshore Services. Provider is prohibited from using any individual or entity ("Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative or other individual or entity) to perform any services for Medicare Plans if the individual or entity is physically located outside of one of the fifty

United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands) ("Offshore Services"), unless Company, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity. Provider further agrees that Company has the right to audit any Offshore Entity prior to the provision of Offshore Services for Medicare Plans. Additionally, Provider acknowledges and agrees that Offshore Services that involve Medicare Member protected health information (PHI) are subject to CMS reporting within thirty (30) days of: (1) performing, or contracting with an Offshore Entity to perform, Offshore Services, and (2) any time Provider changes the Offshore Services that an Offshore Entity will perform.

J. Submission of Encounter Data. Provider hereby acknowledges that Company is required to provide CMS and other federal and state regulatory agencies and accrediting organizations with encounter data as requested by such agencies and organizations. Such data may include medical records and all other data necessary to characterize each encounter between Provider and a Medicare Member. Provider agrees to cooperate with Company and to provide Company with all such information in such form and manner as requested by Company. Provider agrees to immediately notify Company if any encounter data that Provider submitted to Company for Medicare Members is inaccurate, incomplete or erroneous, and cooperate with Company to correct erroneous encounter data to ensure Company's compliance with Medicare laws, rules and regulations and CMS instructions.

K. Certification of Data. Provider recognizes that as a Medicare Advantage organization, Company is required to certify the accuracy, completeness and truthfulness of data that CMS requests. Such data include encounter data, payment data, and any other information provided to Company by its contractors and subcontractors. Provider and its subcontractors, if any, hereby certify that any such data submitted to Company will be accurate, complete and truthful. Upon request, Provider shall make such certification in the form and manner prescribed by Company.

L. Medicare Member Complaints. Provider agrees to cooperate with Company in resolving any Medicare Member complaints related to coverage for the provision of Covered Services. Company will notify Provider as necessary concerning all Medicare Member complaints involving Provider. Provider shall, in accordance with the Provider's regular procedures, investigate such complaints and respond to Company in the required time. Provider shall use best efforts to resolve complaints in a fair and equitable manner.

M. Compliance Program and Anti-Fraud Initiatives. Provider shall (and shall cause its subcontractors to) institute, operate, and maintain an effective compliance program to detect, correct and prevent the incidence of non-compliance with CMS requirements and the incidence of fraud, waste and abuse (FWA) relating to the operation of Company's Medicare Program. Such compliance program shall be appropriate to Provider's or subcontractor's organization and operations and shall include: (a) written policies, procedures and standards of conduct articulating the entity's commitment to comply with federal and state laws, as well as providing mechanisms for employee/subcontractor use in adhering to the expectation that Provider and employee/subcontractor report potential non-compliance or FWA issues (internally and to Company, as applicable); (b) for all officers, directors, employees, contractors and agents of Provider or subcontractor, required participation in effective compliance and anti-fraud training and education that is consistent with guidance that CMS has or may issue with respect to compliance and anti-fraud and abuse initiatives, unless exempt from such training under relevant CMS regulations. This includes general compliance and FWA training completion, as well as code of conduct dissemination, initially within ninety (90) days of hire/contracting and at least annually thereafter; Provider and subcontractors, as applicable, may use Company's code and training or an equivalent; and (c) processes to oversee subcontractors to ensure their compliance with these requirements.

N. Marketing. Consistent with Federal laws, regulations, and agency requirements applicable to the Medicare Advantage Program, Provider shall not: (1) engage in any marketing or sales activities that could mislead or confuse Medicare beneficiaries, or (2) market or advertise non-health care related products to Medicare Members or prospective Medicare Members. Further, Provider shall at all times comply with the then current Medicare Marketing Guidelines.

O. Dual-Eligible Hold Harmless. Provider acknowledges and agrees that Medicare Members who are also enrolled in a State Medicaid plan ("Dual Eligible Members") are not responsible for paying to Provider any Copayments, Coinsurance or Deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when the State Medicaid plan is responsible for paying such Cost Sharing Amounts. Provider further agrees that they will

not collect Cost Sharing Amounts from Dual Eligible Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the Company's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts, or bill the applicable State Medicaid plan for the appropriate Cost Sharing Amounts owed by the State Medicaid plan.

7. COMPANY OBLIGATIONS.
A. Fee Schedule. Company shall arrange for Provider to be compensated for health care services rendered to Medicare Members in accordance with Section 2 of this Addendum.

B. Prompt Pay. In accordance with 42 C.F.R. § 422.520(a)(1), Company shall make best efforts to pay clean claims submitted by Provider for Covered Services provided to Medicare Members within thirty (30) calendar days of receipt. For purposes of this Addendum, the term "clean claim" shall have the meaning assigned in 42 C.F.R. §422.500.

8. GENERAL PROVISIONS
A. Termination. This Addendum may be terminated on its own without respect to the remainder of the Agreement with or without cause by either Party in accordance with the termination provisions of the underlying Agreement. This Addendum shall terminate automatically in the event that the underlying Agreement is terminated in accordance with the termination provisions of the Agreement.

B. Governing Law. This Addendum shall be governed by Federal laws, regulations, and agency requirements applicable to the Medicare Advantage Program. In the event that changes to the governing laws, regulations, or agency requirements applicable to the Medicare Advantage Program occur, the new law, regulation or agency requirement shall supersede to the extent required by any such later required changes.

C. All other terms and provisions of the Agreement not amended hereby shall remain in full force and effect, without modification. In the event of any inconsistency between the terms of this Addendum and the Agreement, the terms of this Addendum shall govern and control.

D. Survival. All provisions of this Addendum which by their nature should survive termination of Provider's provision of Medicare Services under this Agreement or termination of the Agreement as a whole, shall survive termination.

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Schedule 1

Medicare Required Provisions

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement between Company and Provider (referred to in this Schedule 1 as "FDR") not inconsistent herein shall remain in full force and effect. This Exhibit shall supersede and replace any inconsistent provisions to such Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

NOW, THEREFORE, the parties agree as follows:

A. Definitions:

1. Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

2. Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

3. Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

4. Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

5. First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

6. Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

7. Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

8. Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

9. Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

10. Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes

services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

B. <u>Required Provisions</u>:

FDR agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with Company's Affiliates included in this Agreement, (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)] and [42 CFR §423.505]

2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph 1 of this amendment directly from any first tier, downstream, or related entity. For records subject to review under paragraph 1, except in exceptional circumstances, CMS will provide notification to the MA organization that a direct request for information has been initiated. [42 C.F.R. §§ 422.504(i)(2)(ii) and (iii)]

3. FDR will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118] and [42 CFR §423.136]

4. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)] and [42 CFR §423.505(i)(3)(i)]

5. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. FDR may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

6. Any services or other activity performed in accordance with a contract or written agreement by FDR are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)] and [42 CFR §423.505(i)(3)(iii)]

7. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between the MA Organization/Physician and the provider. [42 C.F.R. §§ 422.520(b)(1) and (2)]
   See Section 7.b of the Addendum to which this Schedule 1 is attached.

8. FDR and any related entity, contractor or subcontractor will comply with all applicable Federal and Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)] and [42 CFR §423.505(i)(4)(iv)]

9. If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity:

[INFORMATIONAL NOTE: If there is no delegation of a specific activity or responsibility, please delete the related provision and replace with "None delegated".]

(i) The delegated activities and reporting responsibilities are specified as follows:

[List activities and reporting responsibilities or enter the section and name of the delegation or applicable agreement].

(ii) CMS and the MA organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.

(iii) The MA organization will monitor the performance of the parties on an ongoing basis.

[Enter any applicable section and name of the delegation or applicable agreement].

(iv) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.

[**Enter any applicable section and name of the delegation or applicable agreement].**

(v) If the MA organization delegates the selection of providers, contractors, or subcontractor, the MA organization retains the right to approve, suspend, or terminate any such arrangement.

[42 C.F.R. §§ 422.504(i)(4) and (5)]

In the event of a conflict between the terms and conditions above and the terms of a related agreement, the terms above control.

Aetna Better Health of Iowa
Ancillary Services Agreement

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Aetna Better Health of Iowa

Medicaid Ancillary Services Agreement Checklist

_____ **All** pages of this document must be printed and returned to Aetna Better Health (not just the signature pages).

_____ **Page 1**. The Ancillary name that is filled in on the top of page one must match **exactly** with the name on the W9. Leave the effective date blank. This will be filled in by Aetna Better Health.

_____ **Signature Page.** The signature page must be signed by an authorized ancillary representative. In addition, all information listed below the signature line (TIN, NPI, and Reimbursement Address, etc.) must be completed.

_____ **Ancillary Application**. The Aetna Better Health Ancillary Application must be completed and returned with the signed contract.

_____ **W9**. A W9 form must be returned with the contract. As indicated above, the name on the W9 must match exactly the name listed on pages 1 and the signature page of the Agreement.

Please return all documents to:

Aetna Better Health of Iowa
Attn: Network Management
4320 NW 114th Street
Urbandale, IA 50322

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AETNA BETTER HEALTH OF IOWA
ANCILLARY SERVICES AGREEMENT

The term of this Medicaid Ancillary Services Agreement (the "Agreement") by and between Aetna Better Health of Iowa Inc., an Iowa corporation on behalf of itself and its Affiliates (hereinafter "Company"), and _____ (hereinafter "Provider"), shall commence effective _____, 20___ [Date to be completed by Company] (the "Effective Date"). Company and Provider may be referred to individually as a "Party" and collectively as the "Parties." The Regulatory Compliance Addendum (Exhibit A) and Medicare Compliance Addendum (Exhibit D, including Schedule 1) attached to this Agreement, are expressly incorporated into this Agreement and are binding upon the Parties. In the event of any inconsistent or contrary language between the Addenda and any other part of this Agreement, including but not limited to exhibits, attachments or amendments, the Parties agree that the provisions of the Addenda shall prevail.

WHEREAS, Company administers Plans for Government Sponsors that provide access to health care services to Members or arranges for the provision of health care services to Members of Government Programs; and

WHEREAS, Company contracts with certain health care providers and facilities to provide access to such health care services to Members; and

WHEREAS, Provider provides health care services to patients within the scope of its licensure or accreditation; and

WHEREAS, Company and Provider mutually desire to enter into an arrangement whereby Provider will become a Participating Provider and render health care services to Members; and

WHEREAS, in return for the provision of health care services by Provider, Company will pay Provider for Covered Services under the terms of this Agreement; and

WHEREAS, Provider understands and agrees that Government Sponsors or other government entities may require certain changes to the terms of this Agreement before Provider can provide services to Members under the terms of any Plans that are awarded, by the Government Sponsors, to Company.

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants, promises and undertakings herein, the sufficiency of which is hereby acknowledged, and intending to be legally bound hereby, the parties agree as follows:

1.0 DEFINITIONS

When used in this Agreement, all capitalized terms shall have the following meanings:

Affiliate. Any corporation, partnership or other legal entity (including any Plan) directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company.

Clean Claim. A claim that can be processed without obtaining additional information from the Provider who provided the service or from a third party, except that it shall not mean a claim submitted by or on behalf of a Provider who is under investigation for fraud or abuse, or a claim that is under review for medical necessity; provided, further, unless otherwise required by law or regulation, a claim which (a) is submitted within the proper timeframe as set forth in this Agreement and (b) has (i) detailed and descriptive medical and patient data, (ii) a corresponding referral (whether in paper or electronic format), if required for the applicable claim, (iii) whether submitted via an electronic transaction using permitted standard code sets (e.g., CPT-4, ICD-9 (or successor standard), HCPCS) as required by the applicable Federal or state regulatory authority (e.g., U.S. Dept. of Health & Human Services, U.S. Dept. of Labor, state law or regulation) or otherwise, all the data elements of the UB-04 or CMS-1500 (or successor standard) forms (including but not limited to Member identification number, national provider identifier ("NPI"), date(s) of service, complete and accurate breakdown of services), and (c) does not involve coordination of benefits, and (d) has no defect or error (including any new procedures with no CPT code,

experimental procedures or other circumstances not contemplated at the time of execution of this Agreement) that prevents timely adjudication.

Coinsurance. A payment a Member is required to make under a Plan which is determined as a percentage of the lesser of: (a) the rates established under this Agreement; or (b) Provider's usual, customary and reasonable billed charges.

Confidential Information. Any information that identifies a Member and is related to the Member's participation in a Plan, the Member's physical or mental health or condition, the provision of health care to the Member or payment for the provision of health care to the Member. Confidential Information includes, without limitation, "individually identifiable health information," as defined in 45 C.F.R. § 160.103 and "non-public personal information" as defined in laws or regulations promulgated under the Gramm-Leach-Bliley Act of 1999.

Copayment. A charge required under a Plan that must be paid by a Member at the time of the provision of Covered Services, or at such other time as determined by Provider and which is expressed as a specific dollar amount.

Covered Services. Those health care services for which a Member is entitled to receive coverage under the terms and conditions of a Plan. The Parties agree that Company is obligated to pay for only those Covered Services that are determined to be medically necessary, as determined in accordance with the Member's applicable Plan.

Deductible. An amount that a Member must pay for Covered Services during a specified coverage period in accordance with the Member's Plan before benefits will be paid.

Effective Date. Defined in first paragraph of this Agreement.

Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, her pregnancy or health or the health of her fetus) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part; or such other definition as may be required by applicable law.

Emergency Services. . Covered Services furnished by a qualified provider and necessary to evaluate or stabilize an Emergency Medical Condition.

Government Programs. Plans operated and/or administered by Company pursuant to a State Contract.

Government Sponsor. A state agency or other governmental entity authorized to offer, issue and/or administer one or more Plans, and which, to the extent applicable, has contracted with Company to administer all or a portion of such Plan(s).

Material Change. Any change in Policies that could reasonably be expected, in Company's determination, to have a material adverse impact on (i) Provider's reimbursement for Provider Services or (ii) Provider administration.

Medically Necessary or Medical Necessity. Health care services that a physician or other applicable health care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendation and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member. An individual covered by or enrolled in a Plan.

Participating Provider. Any physician, hospital, hospital-based physician, skilled nursing facility, mental health and/or substance abuse professional (which shall include psychiatrists, psychologists, social workers, psychiatric nurses, counselors, family or other therapists or other mental health/substance abuse professionals), or other individual or entity involved in the delivery of health care or ancillary services who or which has entered into and continues to have a current valid contract with Company to provide Covered Services to Members, and, where applicable, has been credentialed by Company or its designee consistent with the credentialing policies of Company or its designee, as applicable. Certain categories of Participating Providers may be referred to herein more specifically as, e.g., "Participating Physicians" or "Participating Hospitals."

Party. Company or Provider, as applicable. Company and Provider may be referred to collectively as the "Parties."

Plan. A Member's health care benefits as set forth in the State Contract. Such Plans are listed in the **Program Participation Schedule** attached hereto and made a part hereof.

Policies. The policies and procedures promulgated by Company which relate to the duties and obligations of the Parties under the terms of this Agreement, including, but not limited to: (a) quality improvement/management; (b) utilization management, including, but not limited to, precertification of elective admissions and procedures, concurrent review of services and referral processes or protocols; (c) pre-admission testing guidelines; (d) claims payment review; (e) member grievances; (f) provider credentialing; (g) electronic submission of claims and other data required by Company; and (h) any applicable participation criteria required by the State in connection with the Government Programs. Policies also include those policies and procedures set forth in the Company's and/or Government Sponsor's manuals (as modified from time to time) as Company determines appropriate in its sole discretion; clinical policy bulletins made available via Company's internet web site; and other policies and procedures, whether made available via a password-protected web site for Participating Providers (when available), by letter, newsletter, electronic mail or other media.

Post-Stabilization Care Services. Covered Services relating to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, under circumstances defined in federal regulations, to improve or resolve the Member's condition.

Proprietary Information. Any and all information, whether prepared by a Party, its advisors or otherwise, relating to such Party or the development, execution or performance of this Agreement whether furnished prior to or after the Effective Date. Proprietary Information includes but is not limited to, with respect to Company, the development of a pricing structure, (whether written or oral) all financial information, rate schedules and financial terms which relate to Provider and which are furnished or disclosed to Provider by Company. Notwithstanding the foregoing, the following shall not constitute Proprietary Information:

(a) information which was known to a receiving Party (a "Recipient") prior to receipt from the other Party (a "Disclosing Party") (as evidenced by the written records of a Recipient);

(b) information which was previously available to the public prior to a Recipient's receipt thereof from a Disclosing Party;

(c) information which subsequently became available to the public through no fault or omission on the part of a Recipient, including without limitation, the Recipient's officers, directors, trustees, employees, agents, contractors and other representatives;

(d) information which is furnished to a Recipient by a third party which a Recipient confirms, after due inquiry, has no confidentiality obligation, directly or indirectly, to a Disclosing Party; or

(e) information which is approved in writing in advance for disclosure or other use by a Disclosing Party.

Provider. Defined in first paragraph of this Agreement.

Provider Services. Defined in Section 2.1 of this Agreement

Specialty Program. A program for a targeted group of Members with certain types of illnesses, conditions, cost or risk factors.

Specialty Program Providers. Those hospitals, physicians and other providers that have been identified or designated by Company or the Government Sponsor to provide Covered Services associated with a Specialty Program.

State Contract. Company's contract(s) with Government Sponsors to administer Plans or Government Programs identified in the **Program Participation Schedule**.

2.0 PROVIDER SERVICES AND OBLIGATIONS

2.1 Provision of Services.
Provider will make available and provide to Members those Covered Services (along with any related facilities, equipment, personnel or other resources necessary to provide the services according to generally accepted standards of Provider's practice) listed in the **Services and Compensation Schedule** attached hereto and made a part hereof ("Provider Services"). Company and Provider may mutually agree in writing at any time, and from time to time, either to increase or decrease the Provider Services made available to Members under this Agreement.

2.2 Non-Discrimination and Equitable Treatment of Members. Provider agrees to provide Provider Services to Members with the same degree of care and skill as customarily provided to Provider's patients who are not Members, according to generally accepted standards of Provider's practice. Provider and Company agree that Members and non-Members should be treated equitably. Provider agrees not to discriminate against Members on the basis of race, ethnicity, gender, creed, ancestry, lawful occupation, age, religion, marital status, sexual orientation, mental or physical disability, medical history, color, national origin, place of residence, health status, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment for services, cost or extent of Provider Services required, or any other grounds prohibited by law or this Agreement and will abide by Company's cultural competency Policies. Ancillary shall deliver Covered Services in a culturally competent manner to Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds, and comply with Company's Policies on cultural competency.

2.3 Federal Law.
Company is a Federal contractor and an Equal Opportunity Employer which maintains an Affirmative Action Program. To the extent applicable to Provider, Provider, on behalf of itself and any subcontractors, agrees to comply with the following, as amended from time to time: Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq., and regulations promulgated thereunder, Executive Order 11246, the Vietnam Era Veterans Readjustment Act of 1974, the Drug Free Workplace Act of 1988, Section 503 of the Rehabilitation Act of 1973, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") administrative simplification rules at 45 CFR parts 160, 162, and 164, the Americans with Disabilities Act of 1990, Federal laws, rules and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (Section 1128B(b) of the Social Security Act), and any similar laws, regulations or other legal mandates applicable to recipients of federal funds and/or transactions under or otherwise subject to any government contract of Company.

2.4 Provider Representations.

2.4.1 General Representations. Provider represents, warrants and covenants, as applicable, that: (a) it has and shall maintain throughout the term of this Agreement all appropriate license(s) and certification(s) mandated by governmental regulatory agencies; (b) it is, and will remain throughout the term of this Agreement, accredited by The Joint Commission or another applicable accrediting agency recognized by Company; (c) it is, and will remain throughout the term of this Agreement, in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided hereunder, including, without limitation, statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, false claims and prohibition of kickbacks; (d) it is certified to participate in the Medicaid and Medicare programs; (e) it has established an ongoing quality assurance/assessment program which includes, but is not limited to, credentialing of employees and subcontractors and shall supply to Company the relevant documentation, including, but not limited to, internal quality assurance/assessment protocols, state licenses and certifications, Federal agency certifications and/or registrations upon request; (f) all health care personnel employed by, associated or contracted with Provider who treat Members: (i) are and will remain throughout the term of this Agreement appropriately licensed and/or certified (when and as required by state law) and supervised, and qualified by education, training and experience to perform their professional duties; and (ii) will act within the scope of their licensure or certification, as the case may be; (g) its credentialing, privileging, and re-appointment procedures are in accordance with its medical staffs by-laws, regulations, and policies, comply with The Joint Commission standards, meet the querying and reporting requirements of the National Practitioner Data Bank ("NPDB") and Healthcare Integrity and Protection Data Bank ("HIPDB"), and fulfill all applicable state and Federal standards; (h) this Agreement has been executed by its duly authorized representative; and (i) executing this Agreement and performing its obligations hereunder shall not cause Provider to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

2.4.2 Government Program Representations. Company has or shall seek contracts to serve beneficiaries of Government Programs. To the extent Company participates in such Government Programs, Provider agrees, on behalf of itself and any subcontractors of Provider acting on behalf of Provider, to be bound by all rules and regulations of, and all requirements applicable to, such Government Programs. Provider acknowledges and agrees that all provisions of this Agreement shall apply equally to any employees, independent contractors and subcontractors of Provider who provide or may provide Covered Services to Members of Government Programs, and Provider represents and warrants that Provider shall cause such employees, independent contractors and subcontractors to comply with this Agreement, State Contract, and all applicable laws, rules and regulations and perform all requirements applicable to Government Programs. Any such subcontract or delegation shall be subject to prior written approval by Company. With respect to Members of Government Programs, Provider acknowledges that compensation under this Agreement for such Members constitutes receipt of Federal funds. Provider agrees that all services and other activities performed by Provider under this Agreement will be consistent and comply with the obligations of Company and/or Government Sponsor under its contract(s) with the Centers for Medicare and Medicaid Services ("CMS"), and any applicable state regulatory agency, to offer Government Programs. Provider further agrees to allow Government Sponsor, CMS, any applicable state regulatory agency, and Company to monitor Providers' performance under this Agreement on an ongoing basis in accordance with applicable laws, rules and regulations. Provider acknowledges and agrees that Company may only delegate its activities and responsibilities under the State Contract or any Company contract(s) with Government Sponsor, CMS and any applicable regulatory agency, to offer Government Programs in a manner consistent with applicable laws, rules and regulations, and that if any such activity or responsibility is delegated by Company to Provider, the activity or responsibility may be revoked if Government Sponsor, CMS or Company determine that Provider has not performed satisfactorily. Upon request, Provider shall immediately provide to Company any information that is required by Company to meet its reporting obligations to CMS, including without limitation, physician incentive plan information, if applicable. To the extent that Provider generates and/or compiles and provides any data to Company that Company, in turn, submits to CMS, Provider certifies, to the best of its knowledge and belief, that such data is accurate, complete and truthful.

2.4.3 Government Program Requirements. Provider hereby agrees to perform its obligations under this Agreement in accordance with the terms and conditions set forth in Exhibits A and D.

2.4.4 Qualified Providers. Provider shall exclude any physician or other provider from performing services in connection with this agreement if such provider has been suspended or terminated from participation in Government Programs or any other government-sponsored program, including Medicare or the Medicaid program in any state. Provider is prohibited from using any individual or entity ("Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative or other individual or entity) to perform any services for Plans if the individual or entity is physically located outside of one of the fifty United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands.), unless Company, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity. Provider further agrees that Company has the right to audit any Offshore Entity prior to the provision of services for Plans.

2.4.5 Suspension or Debarment. Provider represents, warrants and covenants, as applicable, that it:

a. Has not within a three year period preceding the proposal submission been convicted or had a civil judgment rendered against him/her/it for commission of fraud or criminal offense in performing a public transaction or contract (local, state or federal) or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property; and

b. Is not presently indicted for or otherwise criminally or civilly charged by a governmental entity with the commission of any of the above offenses; and

c. Has not within a five year period preceding execution of this Agreement had one or more public transactions terminated for cause or fault; and

d. Is not excluded, debarred or suspended from participation in any government-sponsored program including, but not limited to, Government Programs, Medicare or the Medicaid program in any state; and

e. Will immediately report any change in the above status to Company; and

f. Will maintain all appropriate licenses to perform its duties and obligations under the Agreement.

2.5 Provider's Insurance.

During the term of this Agreement, Provider agrees to procure and maintain such policies of general and professional liability and other insurance, or a comparable program of self-insurance, at minimum levels as required by state law or, in the absence of a state law specifying a minimum limit, an amount customarily maintained by Provider in the state or region in which the Provider operates. Such insurance coverage shall cover the acts and omissions of Provider as well as those Provider's agents and employees. Provider agrees to deliver certificates of insurance or other documentation as appropriate to show evidence of such coverage to Company upon request. Provider agrees to make best efforts to provide to Company at least thirty (30) days advance notice, and in any event will provide notice as soon as reasonably practicable, of any cancellation or material modification of said policies.

2.6 Program Participation.

Provider agrees to participate in the Plans and other health benefit programs listed on the **Program Participation Schedule**. Company reserves the right to introduce and designate Provider's participation in new Plans, Specialty Programs and other programs during the term of this Agreement and will provide Provider with written notice of such new Plans, Specialty Programs and other programs and the associated compensation. To the extent that Company establishes and/or participates in a provider Pay-for-Performance

incentive program or Performance Improvement Programs, Provider agrees to comply with and participate in such program.

Nothing herein shall require that Company identify, designate or include Provider as a preferred participant in any specific Plan for which Company provides incentives based upon the use of selected Participating Providers, Specialty Program or other program; provided, however, Provider shall accept compensation in accordance with this Agreement for the provision of any Covered Services to Members under a Plan, Specialty Program or other program in which Provider has agreed to participate hereunder.

2.7 Consents to Release Medical Information.
Provider covenants that it will obtain from Members to whom Provider Services are provided, any necessary consents or authorizations to the release of Information and Records to Company, Government Sponsors, their agents and representatives in accordance with any applicable Federal or state law or regulation or this Agreement.

3.0 COMPANY OBLIGATIONS

3.1 Company's Covenants.
Company or Government Sponsors shall provide Members with a means to identify themselves to Provider (e.g., identification cards), explanation of provider payments, a general description of products (e.g. Quick Reference Card), a listing of Participating Providers, and timely notification of material changes in this information. Company shall provide Provider with a means to check eligibility. Company shall include Provider in the Participating Provider directory or directories for the Plans, Specialty Programs and products in which Provider is a Participating Provider, including when Provider is designated as preferred participant, and shall make said directories available to Members. Company reserves the right to determine the content of provider directories.

3.2 Company Representations.
Company represents and warrants that: (a) this Agreement has been executed by its duly authorized representative; and (b) executing this Agreement and performing its obligations hereunder shall not cause Company to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

The parties acknowledge that one or more state governmental authorities may recommend or require that various Company agreements, including this Agreement, be executed prior to the issuance to Company of one or more approvals, consents, licenses, permissions or other authorizations from governmental authorities with jurisdiction over the subject matter of this Agreement, or which Company deems to be necessary or desirable in its sole discretion (collectively, a "License"). Provider agrees that all Company obligations to perform, and all rights of Provider, under this Agreement are expressly conditioned upon the receipt of all Licenses. Failure of Company to obtain any License shall impose no liability on Company under this Agreement.

3.3 Company's Insurance.
Company at its sole cost and expense agrees to procure and maintain such policies of general and/or professional liability and other insurance (or maintain a self-insurance program) as shall be necessary to insure Company and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any service by Company under this Agreement and the administration of Plans.

4.0 CLAIMS SUBMISSIONS, COMPENSATION AND MEMBER BILLING

4.1 Claim Submission and Payment.

4.1.1 Provider Obligation to Submit Claims. Provider agrees to submit Clean Claims to Company for Provider Services rendered to Members. Provider agrees to submit claim and encounter data related to a Member enrolled in a Government Program in the form and manner as specified by Company, and,

Provider certifies that any such data is accurate, complete and truthful. Provider represents that, where necessary, it has obtained signed assignments of benefits authorizing payment for Provider Services to be made directly to Provider. Provider will make best commercial efforts to submit a minimum of eighty-five percent (85%) of its Member claims electronically to Company. For claims Provider submits electronically, Provider shall not submit a claim to Company in paper form unless Company requests paper submissions or fails to pay or otherwise respond to electronic claims submission in accordance with the time frames required under this Agreement or applicable law or regulation. Provider agrees that Company, or the applicable Government Sponsor, will not be obligated to make payments for billings received more than one hundred and twenty (120) days (or such other period required by applicable state law or regulation)from (a) the date of service or, (b) when Company is the secondary payer, from the date of receipt of the primary payer's explanation of benefits. Company may waive this requirement if Provider provides notice to Company, along with appropriate evidence, of other extraordinary circumstances outside the control of Provider that resulted in the delayed submission. In addition, unless Provider notifies Company of its payment disputes within one hundred eighty (180) days or such other time as required by applicable state law or regulation, of receipt of payment from Company, such payment will be considered full and final payment for the related claims. If Provider does not timely bill Company or Government Sponsors, or dispute any payment, timely as provided in this section 4.1.1, Provider's claim for payment will be deemed waived and Provider will not seek payment from Government Sponsors, Company or Members. Provider shall pay on a timely basis all Participating Providers, employees, independent contractors and subcontractors who render Covered Services to Members of Company's Plans for which Provider is financially responsible pursuant to this Agreement.

Provider agrees to permit claim editing to the primary procedure those services considered part of, incidental to, or inclusive of the primary procedure and make other adjustments for inappropriate billing or coding (e.g., rebundling, duplicative procedures or claim submissions, mutually exclusive procedures, gender/procedure mismatches, age/procedure mismatches). To the extent Provider is billing on a CMS 1500, as of the Effective Date, in performing adjustments for inappropriate billing or coding, Company utilizes a commercial software package (as modified by Company for all Participating Providers in the ordinary course of Company's business) which commercial software package relies upon Government Programs and other industry standards in the development of its rebundling logic.

Subject to applicable law: (i) Company may update internal payment systems in response to additions, deletions, and changes to Government Sponsor, CMS, or other industry source codes without obtaining any consent from Provider or any other party, and Company will provide, at the written request of Provider, a copy of the fee schedule in effect at the time of such request; (ii) Company shall not be responsible for communicating such routine changes of this nature, and will update any applicable payment schedules on a prospective basis within ninety (90) days from the date of publication or such longer period as Company determines appropriate in its sole discretion; and (iii) Company shall have no obligation to retroactively adjust claims.

4.1.2 Company Obligation to Pay for Covered Services. Company shall make payments to Provider for Covered Services on a timely basis consistent with the claims payment procedure described at 42 U.S.C. § 1396a(a)(37)(A). Company agrees to pay Provider for non-capitated Covered Services rendered to Members according to the lesser of (i) Provider's actual billed charges or (ii) the rates set forth in the **Services and Compensation Schedule**, attached hereto and made a part hereof. Company must pay ninety percent (90%) of all such Clean Claims from Provider within thirty (30) days following actual receipt; provided, further, Company must pay ninety-nine percent (99%) of all Clean Claims from Provider within ninety (90) days following actual receipt. Provider will make best commercial efforts to utilize online explanation of benefits or electronic remittance of advice (or combination thereof) and electronic funds transfer in lieu of receiving paper equivalents to the extent such services are available from Company. Company reserves the right to recoup any overpayment or payment made in error (e.g., a duplicate payment or payment for services rendered by Provider to a patient who was not a Member and amounts identified through routine investigative reviews of records or audits) against any other monies due to Provider under this Agreement.

In the event that Provider identifies any overpayments by Company, Provider shall, as required under Section 6402(a) of the Patient Protection and Affordable Care Act, report and return any and all such overpayments to Company within sixty (60) days of Provider's identification of any and all such overpayments. In addition, when reporting and returning any such overpayments by Company, Provider must provide Company with a written reason for the overpayment (e.g., excess payment under coordination of benefits, etc.).

To the extent, if any, that the compensation under certain Plans is in the form of capitation payments or a case-based rate methodology, Provider acknowledges the financial risks to Provider of this arrangement and has made an independent analysis of the adequacy of this arrangement. Provider, therefore, agrees and covenants not to bring any action asserting the inadequacy of these arrangements or that Provider was in any way improperly induced by Company to accept the rate of payment, including, but not limited to, causes of actions for damages, rescission or termination alleging fraud or negligent misrepresentation or improper inducement. Notwithstanding anything in this Agreement to the contrary, subcontractors agree to seek compensation solely from Provider for those Covered Services provided to Members and for which Provider is compensated by Company. Subcontractor shall in no event bill Company, its Affiliates, Government Sponsor, or Members for any such Covered Services. Provider will provide Company with a Designation of Payment Schedule from all subcontractors, which will indemnify and hold harmless Company, Government Sponsor and its Members for payment of all compensation owed subcontractor under subcontractor's arrangement with Provider.

Complaints or disputes concerning payments for the provision of services as described in this Agreement shall be subject to the Company's grievance resolution system.

4.1.3 Eligibility Determinations. Company shall have the right to recover payments made to Provider if the payments are for services provided to an individual who is later determined to have been ineligible based upon information that is not available to Company at the time the service is rendered or authorization is provided.

4.1.4 Utilization Management. Company utilizes systems of utilization review/quality improvement/peer review to promote adherence to accepted medical treatment standards and to encourage Participating Providers to minimize unnecessary medical costs consistent with sound medical judgment and in accordance with applicable law. To further this end, Provider agrees, consistent with sound medical judgment and in accordance with applicable law:

(a) To participate, as requested, and to abide by Company's utilization review, patient management, quality improvement programs, and all other related programs (as modified from time to time) and decisions with respect to all Members.

(b) To comply with Company's precertification and utilization management requirements for those Covered Services requiring such notice.

(c) To regularly interact and cooperate with Company's nurse case managers.

(d) To utilize Participating Providers to the fullest extent possible, consistent with sound medical judgment.

(e) To abide by all Company's credentialing criteria and procedures, including site visits and medical chart reviews, and to submit to these processes biannually, annually, or otherwise, when applicable.

(f) To obtain advance authorization from Company prior to any non-Emergency Service admission, and in cases where a Member requires an Emergency Service hospital admission or Post-

stabilization Care Services, to notify Company, both in accordance with Company's Policies then in effect.

For those Members who require services under a Specialty Program, Provider agrees to work with Company in transferring the Member's care to a Specialty Program Provider.

4.2 Coordination of Benefits.

Except as otherwise required under applicable Federal, state law or regulation or a Plan, when Company or a Government Sponsor is secondary payer under applicable coordination of benefit principles, and payment from the primary payer is less than the compensation payable under this Agreement without coordination of benefits, then Company or Government Sponsor will pay Provider the lesser of (i) the copayment, coinsurance and deductible amount for the Covered Services as reported on the explanation of benefits of the primary payer, or (ii) the amount of the difference between the amount paid by the primary payer and the compensation payable under this Agreement, absent other sources of payment. Notwithstanding any other provision of this paragraph, if payment from the primary payer is greater than or equal to the compensation payable under this Agreement without coordination of benefits, neither Company, Government Sponsor nor the applicable Member (in accordance with Section 4.3.2 below) shall have any obligation to Provider. Notwithstanding anything to the contrary in this section, in no event shall Provider collect more than Medicare allows if Medicare is the primary payer. Medicaid is never the primary payer.

4.3 Member Billing.

4.3.1 Permitted Billing of Members. Provider may bill or charge Members only in the following circumstances: (a) applicable Copayments, Coinsurance and/or Deductibles, if any, not collected at the time that Covered Services are rendered; and (b) for services that are not Covered Services only if: (i) the Member's Plan provides and/or Company confirms that the specific services are not covered; (ii) the Member was advised in writing prior to the services being rendered that the specific services may not be Covered Services; and (iii) the Member agreed in writing to pay for such services after being so advised. Provider acknowledges that Company's denial or adjustment of payment to Provider based on Company's performance of utilization management as described in Section 4.1.3 or otherwise is not a denial of Covered Services under this Agreement or under the terms of a Plan, except if Company confirms otherwise under this Section 4.3. Provider may bill or charge individuals who were not Members at the time that services were rendered.

4.3.2 Holding Members Harmless. Provider hereby agrees that in no event, including, but not limited to the failure, denial or reduction of payment by Company, insolvency of Company or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse (i) against Members or persons acting on their behalf (other than Company) or (ii) any settlement fund or other *res* controlled by or on behalf of, or for the benefit of, a Member for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance, Deductibles made in accordance with the terms of the applicable Plan. Provider further agrees that this Section 4.3.2: (a) shall survive the expiration or termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) supersedes any oral or written contrary agreement or waiver now existing or hereafter entered into between Provider and Members or persons acting on their behalf.

4.3.3 Cost Sharing Protections for Dual Eligible Members. Provider acknowledges and agrees that Medicare Members who are also enrolled in a State Medicaid plan ("Dual Eligible Members") are not responsible for paying to Provider any Copayments, Coinsurance or Deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when the State Medicaid plan is responsible for paying such Cost Sharing Amounts. Provider further agrees that they will not collect Cost Sharing Amounts from Dual Eligible Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the Company's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts, or bill the applicable State Medicaid plan for the appropriate Cost Sharing Amounts owed by the State Medicaid plan. Dual Eligible Members in Capitated Financial Alignment Demonstration Plans are not responsible for Cost Sharing Amounts for

Medicare Parts A and B services.

To protect Members, Provider agrees not to seek or accept or rely upon waivers of the Member protections provided by this Section 4.3.

5.0 COMPLIANCE WITH POLICIES

5.1 Policies.

Provider agrees to accept and comply with Policies of which Provider knows or reasonably should have known (e.g., clinical policy bulletins or other Policies made available to Provider). Provider will utilize the electronic real time HIPAA compliant transactions, including but not limited to, eligibility, precertification and claim status inquiry transactions to the extent such electronic real time features are utilized by Company. Company may at any time modify Policies. Company will provide notice by letter, newsletter, electronic mail or other media, of Material Changes. Failure by Provider to object in writing to any Material Change within thirty (30) days following receipt thereof constitutes Provider's acceptance of such Material Change. In the event that Provider reasonably believes that a Material Change is likely to have a material adverse financial impact upon Provider's practice, Provider agrees to notify Company in writing, specifying the specific bases demonstrating a likely material adverse financial impact, and the Parties will negotiate in good faith an appropriate amendment, if any, to this Agreement. Notwithstanding the foregoing, at Company's discretion, Company may modify the Policies to comply with applicable law or regulation, or any order or directive of any governmental agency, without the consent of Provider, and the Policies shall be deemed to be automatically amended to conform with all laws and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over this Agreement. Provider agrees that noncompliance with any requirements of this Section 5.1 or any Policies will relieve Company or Government Sponsors and Members from any financial liability for the applicable portion of the Provider Services.

5.2 Notices and Reporting.

To the extent neither prohibited by law nor violative of applicable privilege, Provider agrees to provide notice to Company, and shall provide all information reasonably requested by Company regarding the nature, circumstances, and disposition, of: (a) any action taken by Provider adversely affecting medical staff membership of Participating Physicians and other Participating Providers, whether or not such actions are reportable to NPDB or HIPDB; (b) any litigation or administrative action brought against Provider or any of its employees, medical staff members or affiliated providers which is related to the provision of health care services and could have a material impact on the Provider Services provided to Members; (c) any investigation initiated by The Joint Commission, another accrediting agency recognized by Company or any government agency or program against or involving Provider or any of its employees, medical staff members or affiliated providers that does or could adversely affect Provider's accreditation status, licensure, or certification to participate in the Medicare or Medicaid programs; (d) any change in the ownership or management of Provider; and (e) any material change in services provided by Provider or licensure status related to such services, including without limitation a significant decrease in medical staff or the closure of a service unit or material decrease in beds. Company and Provider agree to be mutually committed to promoting Member safety and quality. Therefore, Provider will report the occurrence of and waive all charges related to those conditions specified under Section 5001(c) of the Deficit Reduction Act, Section 2702 of the Affordable Care Act and any related or similar federal or state regulation, in accordance with the terms thereof. Provider agrees to use best efforts to provide Company with prior notice of, and in any event will provide notice as soon as reasonably practicable notice of, any actions taken by or against Provider described in this Section 5.2.

5.3 Information and Records.

5.3.1 Maintenance of Information and Records. Provider agrees (a) to maintain Information and Records (as such terms are defined in Section 5.3.2) in a current, detailed, organized and comprehensive manner and in accordance with customary medical practice, Government Sponsor directives, applicable Federal and state laws, and accreditation standards; (b) that all Member medical records and Confidential Information shall be treated as confidential and in accordance with applicable laws; (c) to

maintain such Information and Records for the longer of six (6) years after the last date Provider Services were provided to Member, or the period required by applicable law or Government Sponsor directives; and (d) to maintain Information and Records in accordance with the requirements of Exhibits A and D, as applicable. This Section 5.3.1 shall survive the termination of this Agreement, regardless of the cause of the termination.

5.3.2 Access to Information and Records. Provider agrees that (a) Company (including Company's authorized designee) and Government Sponsors shall have access to all data and information obtained, created or collected by Provider related to Members and necessary for payment of claims, including without limitation Confidential Information ("Information"); (b) Company (including Company's authorized designee), Government Sponsors and Federal, state, and local governmental authorities and their agents having jurisdiction, upon request, shall have access to all books, records and other papers (including, but not limited to, contracts, medical and financial records and physician incentive plan information) and information relating to this Agreement and to those services rendered by Provider to Members ("Records"); (c) consistent with the consents and authorizations required by Section 2.6 hereof, Company or its agents or designees shall have access to medical records for the purpose of assessing quality of care, conducting medical evaluations and audits, and performing utilization management functions; (d) applicable Federal and state authorities and their agents shall have access to medical records for assessing the quality of care or investigating Member grievances or complaints; and (e) Members shall have access to their health information as required by 45 C.F.R. § 164.524 and applicable state law, be provided with an accounting of disclosures of information when and as required by 45 C.F.R. § 164.528 and applicable state law, and have the opportunity to amend or correct the information as required by 45 C.F.R. § 164.526 and applicable state law. Provider agrees to supply copies of Information and Records within fourteen (14) days of the receipt of a request, where practicable, and in no event later than the date required by Government Sponsor directives and any applicable law or regulatory authority. This Section 5.3.2 shall survive the termination of this Agreement, regardless of the cause of termination.

5.3.3 Government Requirements Regarding Records for Medicare Members. In addition to the requirements of Sections 5.3.1 and 5.3.2, with respect to Medicare Plans, Provider agrees to maintain Information and Records (as those terms are defined in Section 5.3) for the longer of: (i) ten (10) years from the end of the final contract period of any government contract of Company, (ii) the date the U.S. Department of Health and Human Services ("HHS"), the U.S. Comptroller General, or their designees complete an audit, or (iii) the period required by applicable laws, rules or regulations. Provider further agrees that, with respect to Medicare Plans, Company and Federal, state and local government authorities having jurisdiction, or their designees, upon request, shall have access to all Information and Records, and that this right of inspection, evaluation and audit of Information and Records shall continue for the longer of (i) ten (10) years from the end of the final contract period of any government contract of Company, (ii) the date HHS, the U.S. Comptroller General, or their designee complete an audit, or (iii) the period required by applicable laws, rules or regulations. This Section 5.3.3 shall survive the termination of this Agreement, regardless of the cause of termination.

5.4 Quality, Accreditation and Review Activities.
Provider agrees to cooperate with any Company quality activities or review of Company or a Plan conducted by the National Committee for Quality Assurance (NCQA) or a state or Federal agency with authority over Company and/or the Plan, as applicable.

5.5 Proprietary Information.

5.5.1 Rights and Responsibilities. Each Party agrees that the Proprietary Information of the other Party is the exclusive property of such Party and that each Party has no right, title or interest in the same. Each Party agrees to keep the Proprietary Information and this Agreement strictly confidential and agrees not to disclose any Proprietary Information or the contents of this Agreement to any third party without the other Party's consent, except (i) to governmental authorities having jurisdiction, (ii) in the case of Company's disclosure, to Members, Government Sponsors, consultants and vendors under contract with Company, and (iii) in the case of Provider's disclosure to Members for

the limited purpose of advising Members of potential treatment options and costs consistent with applicable Federal and state laws. Except as otherwise required under applicable Federal or state law, each Party agrees to not use any Proprietary Information of the other Party, and at the request of the other Party hereto, return any Proprietary Information upon termination of this Agreement for whatever reason. Notwithstanding the foregoing, Provider is encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which the Provider is paid. Provider is encouraged to discuss Company's provider payment methodology with their patients, including descriptions of the methodology under which the Provider is paid. In addition, Provider through its staff may freely communicate with patients about their treatment options, regardless of benefit coverage limitations. This Section 5.5.1 shall survive the termination of this Agreement for one (1) year, regardless of the cause of termination.

6.0 TERM AND TERMINATION

6.1 Term.
This Agreement shall be effective for an initial term ("Initial Term") of one (1) year from the Effective Date, and thereafter shall automatically renew for additional terms of one (1) year each, unless and until terminated in accordance with this Article 6.0.

6.2 Termination without Cause.
This Agreement may be terminated by Company at any time without cause with at least ninety (90) days prior written notice to Provider. This Agreement may be terminated by Provider without cause at any time following the conclusion of the Initial Term with at least ninety (90) days prior written notice to Company.

6.3 Termination for Breach.
This Agreement may be terminated at any time by either Party upon at least thirty (30) days prior written notice of such termination to the other Party upon material default or substantial breach by such Party of one or more of its obligations hereunder, unless such material default or substantial breach is cured within thirty (30) days of the notice of termination; provided, however, if such material default or substantial breach is incapable of being cured within such thirty (30) day period, any termination pursuant to this Section 6.3 will be ineffective for the period reasonably necessary to cure such breach if the breaching party has taken all steps reasonably capable of being performed within such thirty (30) day period. Notwithstanding the foregoing, the effective date of such termination may be extended pursuant to Section 6.6 herein.

6.4 Immediate Termination or Suspension.
Any of the following events shall result in the immediate termination or suspension of this Agreement by Company, upon notice to Provider, at Company's discretion at any time: (a) the withdrawal, expiration or non-renewal of any Federal, state or local license, certificate, approval or authorization of Provider; (b) the bankruptcy or receivership of Provider, or an assignment by Provider for the benefit of creditors; (c) the loss or material limitation of Provider's insurance under Section 2.5 of this Agreement; (d) a determination by Company that Provider's continued participation in provider networks could result in harm to Members; (e) the exclusion, debarment or suspension of Provider from participation in any governmental sponsored program, including, but not limited to, Government Programs, Medicare or the Medicaid program in any state; (f) the indictment or conviction of Provider for any crime; (g) the revocation or suspension of Provider's accreditation by The Joint Commission or any other applicable accrediting agency recognized by Company; (h) the listing of Provider in the HIPDB; (i) change of control of Provider to an entity not acceptable to Company; or (j) the withdrawal, expiration or termination of the State Contract. To protect the interests of patients, including Members, Provider will provide immediate notice to Company of any of the aforesaid events described in clauses (a) through (i), including notification of impending bankruptcy.

6.5 Obligations Following Termination.
Following the effective date of any expiration or termination of this Agreement or any Plan, Provider and Company will cooperate as provided in this Section 6.5 and in Exhibits A and D, as applicable. This Section 6.5 and Exhibits A and D, as applicable shall survive the termination of this Agreement, regardless of the cause of termination.

6.5.1 Upon Termination. Upon expiration or termination of this Agreement for any reason, other than termination by Company in accordance with Section 6.4 above, Provider agrees to provide Provider Services at Company's discretion to: (a) any Member who is receiving services from Provider as of the effective date of termination until the Member's course of treatment is completed or Company's orderly transition of such Member's care to another provider; and (b) any Member, upon request of such Member or the applicable Plan Sponsor, for one (1) calendar year. The terms of this Agreement, including the **Services and Compensation Schedule** shall apply to all services under this Agreement 6.5.1.

6.5.2 Upon Insolvency or Cessation of Operations. If this Agreement terminates as a result of insolvency or cessation of operations of Company, and as to Members of HMOs that become insolvent or cease operations, then in addition to other obligations set forth in this section, Provider shall continue to provide Provider Services to: (a) all Members for the period for which premium has been paid; and (b) Members confined as inpatients on the date of insolvency or other cessation of operations until medically appropriate discharge. This provision shall be construed to be for the benefit of Members. No modification of this provision shall be effective without the prior written approval of the applicable regulatory agencies.

6.5.3 Obligation to Cooperate. Upon notice of expiration or termination of this Agreement or of a Plan, Provider shall cooperate with Company and comply with Policies, if any, in the transfer of Members to other providers.

6.6 Obligations During Dispute Resolution Proceedings.
In the event of any dispute between the Parties in which a Party has provided notice of termination under Section 6.3 and the dispute is required to be resolved or is submitted for resolution under Article 8.0 below, the termination of this Agreement shall be stayed and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

7.0 RELATIONSHIP OF THE PARTIES

7.1 Independent Contractor Status.
The relationship between Company and Provider, as well as their respective employees and agents, is that of independent contractors, and neither shall be considered an agent or representative of the other Party for any purpose, nor shall either hold itself out to be an agent or representative of the other for any purpose. Company and Provider will each be solely liable for its own activities and those of its agents and employees, and neither Company nor Provider will be liable in any way for the activities of the other Party or the other Party's agents or employees arising out of or in connection with: (a) any failure to perform any of the agreements, terms, covenants or conditions of this Agreement; (b) any negligent act or omission or other misconduct; (c) the failure to comply with any applicable laws, rules or regulations; or (d) any accident, injury or damage. Provider acknowledges that all Member care and related decisions are the responsibility of Provider and its medical staff, and that Policies do not dictate or control Provider's clinical decisions with respect to the care of Members. Provider agrees to indemnify and hold harmless the Government Sponsor and Company from any and all claims, liabilities and third party causes of action arising out of the Provider's provision of care to Members. Company agrees to indemnify and hold harmless the Provider from any and all claims, liabilities and third party causes of action arising out of the Company's administration of health care services in connection with the Plans. This provision shall survive the expiration or termination of this Agreement, regardless of the reason for termination.

7.2 Use of Name.
Provider consents to the use of Provider's name and other identifying and descriptive material in provider directories and in other materials and marketing literature of Company in all formats, including, but not limited to, electronic media. Provider may use Company's names, logos, trademarks or service marks in marketing materials or otherwise, upon receipt of Company's prior written consent, which shall not be unreasonably withheld.

7.3 Interference with Contractual Relations.

Provider shall not engage in activities that will cause Company to lose existing or potential Members, including but not limited to: (a) advising Company customers, Government Sponsors or other entities currently under contract with Company to cancel, or not renew said contracts; (b) impeding or otherwise interfering with negotiations which Company is conducting for the provision of health benefits or Plans; or (c) using or disclosing to any third party membership lists acquired during the term of this Agreement for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Notwithstanding the foregoing, Company shall not prohibit, or otherwise restrict, Provider from advising or advocating on behalf of a Member who is his or her patient, for the following: (i) the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; (ii) any information the Member needs in order to decide among all relevant treatment options; (iii) the risks, benefits, and consequences of treatment or nontreatment; and (iv) the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. This section shall continue to be in effect for a period of one (1) year after the expiration or termination of this Agreement.

8.0 DISPUTE RESOLUTION

8.1 Member Grievance Dispute Resolution.

Provider agrees to (a) cooperate with and participate in Company's applicable appeal, grievance and external review procedures (including, but not limited to, Medicaid appeals and expedited appeals procedures), (b) provide Company with the information necessary to resolve same, and (c) abide by decisions of the applicable appeals, grievance and review committees. Company will make available to Provider information concerning the Member appeal, grievance and external review procedures at the time of entering into this Agreement.

8.2 Provider Dispute Resolution.

Company shall provide a mechanism whereby Provider may raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Provider shall exhaust this mechanism prior to instituting any arbitration or other permitted legal proceeding. The Parties agree that any dispute that may arise between the Parties shall not disrupt or interfere with the provision of services to Members. Discussions and negotiations held pursuant to this Section 8.2 shall be treated as inadmissible compromise and settlement negotiations for purposes of applicable rules of evidence.

8.3 Arbitration.

Any controversy or claim arising out of or relating to this Agreement including breach, termination, or validity of this Agreement, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration. Upon mutual consent of the parties, the arbitration will be administered by the American Arbitration Association ("AAA") or the Judicial Arbitration and Mediation Services ("JAMS") and conducted by a sole Arbitrator. If a party believes that the arbitrator has committed an error of law or legal reasoning, the party can appeal to a court of competent jurisdiction to correct any such error of law or legal reasoning. Depositions for discovery purposes shall not be permitted. The arbitrator may award only monetary damages in accordance with this Agreement.

8.4 Arbitration Solely Between Parties; No Consolidation or Class Action.

Any arbitration or other proceeding related to a dispute arising under this Agreement shall be conducted solely between them. Neither Party shall request, nor consent to any request, that their dispute be joined or consolidated for any purpose, including without limitation any class action or similar procedural device, with any other proceeding between such Party and any third party.

9.0 MISCELLANEOUS

9.1 Amendments.

This Agreement constitutes the entire understanding of the Parties hereto and no changes, amendments or alterations shall be effective unless signed by both Parties, except as expressly provided herein. Company may amend this Agreement upon thirty (30) days prior written notice, by letter, newsletter, electronic mail or

other media (an "Amendment"). Failure by Provider to object in writing to any such Amendment within thirty (30) days following receipt thereof constitutes Provider's acceptance of such Amendment. In the event that Provider reasonably believes that an Amendment is likely to have a material adverse impact upon Provider, Provider agrees to notify Company in writing, specifying the specific bases demonstrating a likely material adverse impact, and the Parties will negotiate in good faith an appropriate revised Amendment, if any, to this Agreement. Notwithstanding the foregoing, at Company's discretion, Company may amend this Agreement to comply with applicable law or regulation, or any order or directive of any governmental agency, without the consent of Provider, and this Agreement shall be deemed to be automatically amended to conform with all laws and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over this Agreement. Provider agrees that noncompliance with any requirements of this Section 9.1 will relieve Company or Government Sponsors and Members from any financial liability for the applicable portion of the Provider Services. Changes to Policies are addressed by Section 5.1 hereto.

9.2 Waiver.
The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, all waivers must be in writing and signed by an authorized officer of the Party to be charged. Provider waives any claims or cause of action for fraud in the inducement or execution related hereto.

9.3 Governing Law.
This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State of Iowa.

9.4 Liability.
Notwithstanding Section 9.3, either Party's liability, if any, for damages to the other Party for any cause whatsoever arising out of or related to this Agreement, and regardless of the form of the action, shall be limited to the damaged Party's actual damages. Neither Party shall be liable for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whatsoever sustained as a result of a breach of this Agreement or any action, inaction, alleged tortious conduct, or delay by the other Party.

9.5 Severability.
Any determination that any provision of this Agreement or any application thereof is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Neither Party shall assert or claim that this Agreement or any provision hereof is void or voidable if such Party performs under this Agreement without prompt and timely written objection.

9.6 Successors; Assignment.
This Agreement relates solely to the provision of Provider Services by Provider and does not apply to any other organization which succeeds to Provider assets, by merger, acquisition or otherwise, or is an affiliate of Provider. Neither Party may assign its rights or its duties and obligations under this Agreement without the prior written consent of the other Party, which consent may not be unreasonably withheld; provided, however, that Company may assign its rights or its duties and obligations to an Affiliate or successor in interest so long as any such assignment or delegation will not have a material impact upon the rights, duties and obligations of Provider.

9.7 Headings.
The headings contained in this Agreement are included for purposes of convenience only, and shall not affect in any way the meaning or interpretation of any of the terms or provisions of this Agreement.

9.8 Notices.

Except for any notice required under Article 6, Term and Termination, or if otherwise specified, notices required pursuant to the terms and provisions hereof may be effective if sent by letter, electronic mail or other generally accepted media. With respect to notices required under Article 6, notices shall be effective only if given in writing and sent by overnight delivery service with proof of receipt, or by certified mail return receipt requested. Notices shall be sent to the addresses set forth on the signature page of this Agreement (which addresses may be changed by giving notice in conformity with this Section 9.8). Provider shall notify Company of any changes in the information provided by Provider related to Provider's address.

9.9 Remedies.

Notwithstanding Sections 8.3 and 9.4, the Parties agree that each has the right to seek any and all remedies at law or equity in the event of breach or threatened breach of Section(s) 5.5, 6.6 and 7.3.

9.10 Non-Exclusivity.

This Agreement is not exclusive, and nothing herein shall preclude either Party from contracting with any other person or entity for any purpose. Company makes no representation or guarantee as to the number of Members who may select or be assigned to Provider.

9.11 Force Majeure.

If either Party shall be delayed or interrupted in the performance or completion of its obligations hereunder by any act, neglect or default of the other Party, or by an embargo, war, act of terror, riot, incendiary, fire, flood, earthquake, epidemic or other calamity, act of God or of the public enemy, governmental act (including, but not restricted to, any government priority, preference, requisition, allocation, interference, restraint or seizure, or the necessity of complying with any governmental order, directive, ruling or request) then the time of completion specified herein shall be extended for a period equivalent to the time lost as a result thereof. This Section 9.11 shall not apply to either Party's obligations to pay any amounts owing to the other Party, nor to any strike or labor dispute involving such Party or the other Party.

9.12 Confidentiality.

It is further understood and agreed by and among the Parties that the terms and conditions of this Agreement, except as otherwise specified, are and shall remain confidential, and shall not be disclosed by either Party without express written consent of the other Party or as required by law or by governmental authorities or by express order by a court having jurisdiction over the Party from whom disclosure is sought.

9.13 Entire Agreement.

This Agreement (including any attached schedules, appendices and/or addenda) constitutes the complete and sole contract between the Parties regarding the subject matter described above and supersedes any and all prior or contemporaneous oral or written representations, communications, proposals or agreements not expressly included in this Agreement and may not be contradicted or varied by evidence of prior, contemporaneous or subsequent oral representations, communications, proposals, agreements, prior course of dealings or discussions of the Parties. The Parties understand and agree that this Agreement only applies to the Plans described in this Agreement and, likewise, this Agreement does not and will not supersede any agreement(s) between Company's affiliates and Provider that relates to Company's affiliates other lines of business that are not the subject of this Agreement (that are not the Plans described in this Agreement).

9.14 Signatures. Facsimile and electronic signatures shall be deemed to be original signatures for all purposes of this Agreement.

9.15 Incorporation of Recitals. The Parties incorporate the recitals into this Agreement as representations of fact to each other.

IN WITNESS WHEREOF, the undersigned parties have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.

Provider Sign Here

PROVIDER	**COMPANY**
By:_____	By:_____
Printed Name:_____	Printed Name:_____
Title:_____	Title:_____
Date:_____	Date:_____

REIMBURSEMENT ADDRESS:

_____
_____
_____

MAIN TELEPHONE NUMBER:_____

CHIEF EXECUTIVE OFFICER:_____

CHIEF FINANCIAL OFFICER:_____

BUSINESS OFFICE MANAGER:_____

FEDERAL TAX I.D. NUMBER:_____

NPI NUMBER:_____

As required by Section 9.8 ("Notices") of this Agreement, notices shall be sent to each Party at the following addresses:

To Provider at:
_____
_____
_____
_____

To Company at:

Aetna Better Health of Iowa
Attn: Network Managment
4320 NW 114th Street
Urbandale, IA 50322

With a copy to:
Aetna
Law Dept, Medicaid, Mail Code RE6A
151 Farmington Avenue
Hartford, CT 06156-0001

PROGRAM PARTICIPATION SCHEDULE

Iowa Medicaid managed care Plans offered by Aetna Better Health of Iowa Inc., pursuant to contract with the Iowa Department of Human Services for delivery of high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa hawk-i programs.

SERVICES AND COMPENSATION SCHEDULE

1.0 COMPENSATION

Iowa Medicaid, CHIP & QHP Plans:	Aetna Medicaid Market Fee Schedule
Iowa Medicare Plans:	Medicare Allowable Rate

2.0 SERVICES

Provider will be reimbursed for those Covered Services in accordance with the terms of this Agreement that are within the scope of and appropriate to the Provider's license and certification to practice.

3.0 GENERAL COMPENSATION TERMS AND CONDITIONS

Definitions

"Aetna Medicaid Market Fee Schedule (AMMFS)" – A fee schedule that is based upon the contracted location where service is performed and the State of Iowa Medicaid Fee Schedule.

"Medicare Allowable" - the current payment as of discharge date that a hospital will receive from Company, subject to the then current Medicare Inpatient Prospective Payments Systems and will be updated in accordance with CMS changes, provided, however, that exempt units for psychiatric, rehabilitation and skilled nursing facility services will be paid in accordance with the applicable Medicare Prospective Payment Systems. These payments are intended to mirror the payment a Medicare Fiscal Intermediary ("FI") would make to the hospital, less (with respect to DRG-based payments) the payments for Indirect Medical Education (IME), Direct Graduate Medical Education (DGME), bad debt, as appropriate and adjusted by CMS or Government Sponsor for sequestration, SGR or other items and Aetna payment and processing guidelines. For other provider types, the Medicare allowable rate is based upon CMS Geographic Pricing Cost Indices (GPCI) and Resource Based Relative Value Scale (RBRVS) Relative Value Units (RVU) including Outpatient Prospective Payment System (OPPS) cap rates; the Clinical Laboratory Fee Schedule (CLAB); the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule; including PEN (DMEPOS) and 'Medicare Part B Drug Average Sales Price (ASP),' as appropriate. Coding and fees determined under this schedule will be updated as CMS releases code updates, changes in the MFS relative values, including OPPS cap payments, or the CMS conversion factors. Company plans to update the schedule within 90 days of the final rates and/or codes being published by CMS. However, the rates and coding sets for these services do not become effective until updates are completed by Company and payment is considered final and exclusive of any retroactive or retrospective CMS adjustments to the rate. Company payment policies apply to services paid based upon the Medicare allowable rate.

General

A. Member Cost Share. Rates are inclusive of any applicable Member Copayment, Coinsurance or Deductible.

B. Billing. When billing, Provider must designate applicable codes related to those Covered Services provided by Provider under the terms of this Agreement.

C. Coding. Company utilizes nationally recognized coding structures including, but not limited to, Revenue Codes as described by the Uniform Billing Code, AMA Current Procedural Terminology (CPT4), CMS Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), ICD-9 (or successor standard) Diagnosis and Procedure codes, and National Drug Codes (NDC). As changes are made to nationally-recognized codes, Company will update internal systems to accommodate new codes. Such changes will only be made when there is

no material change in the procedure itself. Until updates are complete, the procedure will be paid according to the standards and coding set for the prior period.

The use of ICD-10 coding shall not impact the aggregate rates and compensation intended by the Parties as set forth in this Services and Compensation Schedule. Consequently, in the event that use of ICD-10 codes result in aggregate payments that would differ from the aggregate payments that would have resulted based on ICD-9 coding (excluding utilization and validated case mix severity changes), the rates set forth in this Services and Compensation Schedule will be reviewed by Company periodically and adjusted at least annually in order to reflect what would have been paid had ICD-9 coding been utilized for determination of the payments.

Company will comply and utilize nationally recognized coding structures as directed under applicable Federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act (HIPAA).

D. Affordable Care Act Primary Care Enhancement. For those primary care Covered Services that the State of Iowa has determined to reimburse at 100% of the Medicare allowable amount in accordance with Section 1902(a)(13)(C) of the Social Security Act, for so long as the rates are in effect and so long as Provider meets the requirements of applicable law for the rates, Company shall compensate Provider for the provision of such Covered Services to eligible Members delivered in accordance with the terms and conditions set forth in this Agreement at the lesser of Hosptial's billed charges or an amount equal to but not greater than the State's enhanced rates. Provider certifies that, to the extent required by law, such payments will insure to the benefit of the individual Participating Physicians, and will supply Company with any legally-required documentation of such. Company reserves the right i) to pay such enhanced compensation through monthly or quarterly adjustment; ii) to make payments directly to qualifying Participating Physicians; and/or iii) to require such Physicians or Hospital to complete any agreements, forms, attestations or releases needed to effectuate such payments. Enhanced compensation is not available for Members of CHIP Plans.

E. Medicare-Medicaid Dual-Eligibles – Where Company is the responsible payor for Medicare and Medicaid Covered Services, rates for each service are determined by whether that service is regarded as a Medicare Covered Service or a Medicaid Covered Service by CMS and Government Sponsor, and with respect to a Member's benefit limits under each program. For Medicare Covered Services (inclusive of Member Copayment or Coinsurance), Company shall compensate provider at the specified Medicare rate. For Medicaid Covered Services, Company shall compensate provider according to the applicable Medicaid rate. When a service is covered under Medicare and Medicaid, Company will determine the rate (Medicare or Medicaid) according to applicable law, coordination of benefit principles and the terms of Member's Plan. Rates do not include, and Company is not responsible for, supplemental or wrap-around payments unless required by Company's contracts with Government Sponsor.

Exhibit A
Iowa Regulatory Compliance Addendum

This Regulatory Compliance Addendum is incorporated by reference into the Agreement. It applies to Iowa Medicaid managed care plans offered by Better Health of Iowa Inc. ("Company"), pursuant to contract with the Iowa Department of Human Services (DHS) for delivery of high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa hawk-i programs and the eligible populations covered by the State Contract between Company and DHS. This Addendum is effective as of the Effective Date of the Agreement.

Provider agrees that all applicable terms and conditions set out in the RFP, the State Contract, any incorporated documents and all applicable state and federal laws, as amended, govern the duties and responsibilities of the Provider with regard to the provision of services to members in the programs applicable hereto. The RFP and State Contract may currently be found at: http://bidopportunities.iowa.gov/?pgname=viewrfp&rfp_id=11140

If there is any conflict between the terms of this Addendum and any of the other terms of the Agreement, including any attachments, schedules, exhibits and/or addenda made part of the Agreement, the terms of this Addendum will govern and control; provided, however, if there is any conflict between any of the terms of the Agreement, including this Addendum, and the State Contract, then the terms of the State Contract will govern and control. For purposes of this Regulatory Compliance Addendum, the term "Provider" shall mean the health care physician, provider, group, facility or hospital executing the Agreement, as identified on the first page of the Agreement.

1.0 DEFINITIONS [taken from the RFP Glossary]

When used in this Agreement, all capitalized terms shall have the following meanings:

Children's Health Insurance Program ("CHIP"). The program created in 1997 by Title XXI of the Social Security Act and known in Iowa as CHIP.

Claim. A formal request for payment for benefits received or services rendered.

CMS. The Centers for Medicare and Medicaid Services.

Co-Payment. A cost-sharing arrangement in which a Member pays a specified charge for a specified service; also called a co-pay.

Covered Services. Those health care services/benefits to which an individual eligible for Medicaid/CHIP is entitled under the Iowa Medicaid State Plan and which Company is required to provide or arrange for pursuant to the State Contract.

IDPH. Iowa Department of Public Health.

IDPH Participants. A resident of the State of Iowa with an income at or below 200% of the federal poverty guidelines as published by the Department of Health and Human Services who is not insured or for whom third party payment is not available to pay for services. An Iowa Medicaid member shall not be an IDPH Participant. An Iowa Health and Wellness Plan member may be an IDPH Participant for those IDPH-funded substance use disorder services that are not fully covered by the Iowa Health and Wellness Plan.

Iowa Department of Human Services ("DHS"). The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Iowa.

Iowa Medicaid State Plan. The binding written agreement between DHS and CMS, which describes how the Medicaid program is administered and determines the services for which DHS will receive federal financial participation.

Medicaid. A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act Amendment. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving covered individuals.

Medical Records. All medical, behavioral health, and long-term care histories; records, reports and summaries; diagnoses; prognoses; record of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, behavioral health, and long-term care documentation in written or electronic format; and analyses of such information.

Medically Necessary Services. Those Covered Services that are, under the terms and conditions of the State Contract, determined through Company utilization management to be:

(1) Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the Member;

(2) Provided for the diagnosis or direct care and treatment of the condition of the Member enabling the Member to make reasonable progress in treatment;

(3) Within standards of professional practice and given at the appropriate time and in the appropriate setting;

(4) Not primarily for the convenience of the Member, the Member's physician or other provider; and

(5) The most appropriate level of Covered Services, which can safely be provided.

Member. A Medicaid recipient who is subject to mandatory enrollment or is currently enrolled in Company's coverage under the State Contract.

Policies. In addition to the policies and procedures promulgated by Company, which relate to the duties and obligations of the Parties under the terms of the Agreement, Policies include the general principles by which DHS is guided in its management of the Title XIX program, as further set forth and defined by DHS promulgations and by state and federal rules and regulations.

Provider Preventable Conditions. Situations in which Medicaid payment is prohibited for services that should have been avoidable as defined in 42 CFR §447.26.

State Contract. The written agreement between Company and DHS, a copy of which may be found by Provider on the State's website. The State Contract is comprised of and incorporates all provisions of the RFP and any addenda, appendices, attachments or amendments thereto, as well as any Member handbook, provider handbook and/or other applicable policy guides, manuals and materials.

2.0 PROVIDER SERVICES AND OBLIGATIONS

2.1 Medical Necessity.
Provider agrees that for the purposes of Covered Services to Members, "Medically Necessary Services" shall be as defined above in this Addendum.

2.2 Timely Access.
Provider must meet the standards for timely access to care and services for Members as set forth on Exhibit B to the RFP, taking into account the urgency of the need for services. Provider must offer hours of operation to Members that are no less than the hours of operation offered to other non-Medicaid patients, or if Provider serves only Medicaid beneficiaries, hours of operation comparable to the hours of operation offered to enrollees of any Iowa Medicaid Fee for Service Program. Provider agrees to provide Covered Services to Members on a twenty-four (24) hour per day, seven (7) day per week basis. [42 CFR 438.209]

2.3 Inability To Pay Co-Payment.

Provider shall not deny care or services to any Member because of the Member's inability to pay the Co-Payment. [RFP SOW §5.3.5]

2.4 Medical Records.

Provider shall create and maintain Medical Records for Members in accordance with applicable law including, but not limited to, Iowa Administrative Code Title 441, Chapter 79.3 and Policies. Without limiting the foregoing, Provider's records must be maintained in a manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical Records must be legible, signed, dated and maintained as required by law. Provider shall provide a copy of the Member's Medical Record to the Member upon reasonable request by the Member at no charge. Provider shall facilitate the transfer of a Member's Medical Record to another provider at the Member's request. Provider must maintain the confidentiality of and access to Medical Records in accordance with the standards mandated in the Health Insurance Portability and Accountability Act and all other state and federal requirements. Provider shall permit Company, representatives of DHS, and other authorized entities to review Members' Medical Records for purpose of monitoring Provider's compliance with the record standards, capturing information for clinical studies, monitoring quality or any other reason. Without limiting the foregoing, Provider will release mental health information regarding Members only as allowed by Iowa Code §228. [RFP SOW §6.1.9 & 2.15]

2.5 Member Rights.

Provider shall take Members' rights as set forth in law into account when providing services to Members. Such rights include the right to receive information as set forth in 42 CFR §438.100, the right to be treated with respect and with due consideration for his or her dignity and privacy; the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand; the right to participate in decisions regarding his or her health care, including the right to refuse treatment; the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion; the right to treatment in the least restrictive setting; the right to fully participate in the community and to work, live and learn to the fullest extent possible; and the right to be furnished health care services in accordance with 42 CFR §§438.206 through 438.210. [RFP SOW §1.4.1]

2.6 Critical Incidents.

If Provider is a provider who has personal contact with Members under the Home-and-Community-Based Services (HCBS) habilitation and waiver services, Provider shall (i) report critical incidents; (ii) respond to critical incidents; (iii) document critical incidents; and (iv) cooperate with any investigation conducted by Company or an outside agency. Provider shall complete any critical incident training required by Company. [RFP SOW §10.4.2]

2.7 Enforcement of §6032 of the 2005 Deficit Reduction Act (DRA).

If Provider receives five million dollars ($5,000,000) or more in Medicaid payments in a federal fiscal year, Provider shall have written policies for all employees, including management, and for all employees of any contractor or agent, that provide detailed information about the following: [RFP SOW §12.12]

a. The Federal False Claims Act under title 31 of the United States Code, sections 3729 through 3733;

b. Administrative remedies for false claims and statements under title 31 of the United States Code, chapter 38;

c. Any State laws pertaining to civil or criminal penalties for false claims and statements (Iowa Code 249A.8 and 714.8(10)-714.14);

d. Whistleblower protections under such laws; and

e. The Provider's policies and procedures for detecting and preventing fraud, waste, and abuse.

2.8 Additional Duties For Nursing Facilities. If Provider is a nursing facility, Provider shall: [RFP SOW §6.1.2.1]

a. Promptly notify Company of a Member's admission or request for admission to the nursing facility as soon as the facility has knowledge of such admission or equest for admission;

b. Notify the Company immediately if the nursing facility is considering discharging a Member and to consult with the Member's care coordinator;

c. Notify the Member and/or the Member's representative (if applicable) in writing prior to discharge in accordance with state and federal requirements;

d. Collect from any Member the Member's patient liability amount as communicated to Provider by Company. Provider agrees that payments from Company to Provider will be net of the applicable patient liability amount for any Member with patient liability.

e. Notify Company of any change in a Member's medical or functional condition that could impact the Member's level of care eligibility for the currently authorized level of nursing facility services;

f. Comply with federal Preadmission Screening and Resident Review ("PASRR") requirements to provide or arrange to provide specialized services and all applicable Iowa law governing admission, transfer and discharge policies; and

g. hereby agrees that the Agreement will automatically be terminated in accordance with federal requirements if Provider is involuntarily decertified by the State or CMS.

2.9 Additional Duties for Home and Community-Based Services. If Provider provides Home and Community-Based Services, Provider shall: [RFP SOW §6.1.2.2]

a. Provide at least thirty (30) days advance notice to the Company when the Provider is no longer willing or able to provide services to a Member and to cooperate with the Member's care coordinator to facilitate a seamless transition to alternate providers;

b. In the event that a HCBS provider change is initiated for a Member, regardless of any other provision in Agreement, continue to provide services to the Member in accordance with the Member's plan of care until the Member has been transitioned to a new provider, as determined by the Company, or as otherwise directed by the Company, which may exceed thirty (30) days from the date of notice to the Company;

c. Immediately report any deviations from a Member's service schedule to the Member's care coordinator;

d. Comply with the critical incident reporting requirements.

e. Comply with all child and dependent adult abuse reporting requirements.

2.10 Additional Duties for Community-Based Services Providers For Resident Transfer and Discharge. Neither Company nor Provider shall transition nursing facility, ICF/ID, 1915(i) Habilitation or 1915(c) community-based residential alternative residents to another facility or residence unless: (i) the Member or

his/her representative specifically requests to transition; (ii) the Member or his/her representative provides written consent to transition based on quality or other concerns raised by the Company or Provider, which shall not include the residential provider's rate of reimbursement; or (iii) the provider has chosen not to contract with the Company. The Company shall establish contractual terms with its providers, subject to approval by DHS, that protects an individual from involuntary discharge that may lead to a placement in an inappropriate or more restrictive setting. The Company shall facilitate a seamless transition whenever a Member transitions between facilities or residences. [RFP SOW §4.3.10]

2.11 Additional Duties for Providers with IDPH Participants.
If Provider provides services to IPDH Participants who are intravenous ("IV") drug users, Provider shall perform outreach activities. Provider shall select, train and supervise outreach workers. Provider shall encourage individuals needing IV treatment to undergo treatment and provide awareness about the relationship between IV drug use and communicable disease. Provider shall use outreach models that are applicable to the local situation and use an approach that can be expected to be reasonably effective. [RFP SOW §3.2.8.15]

2.12 Additional Duties for IHH Providers.
If Provider provides integrated health homes services, Provider agrees to provide the following: (i) quality-driven, cost-effective, culturally appropriate, and person-and family-driven health home services; (ii) high-quality health care services informed by evidence-based clinical practice guidelines; (iii) preventive and health promotion services informed by evidence-based clinical practice guidelines; (iv) preventive and health promotion services, including prevention of mental illness and substance use disorders; (v) comprehensive care management, care coordination and transitional care across settings; (vi) chronic disease management, including self-management support to Members and their families; (vii) demonstrating a capacity to use health information technology to link services, facilitate communication among team members and between the health home team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and (viii) establishing a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level. [RFP SOW §3.2.9.1.2]

3.0 CLAIMS SUBMISSION, COMPENSATION AND MEMBER BILLING

3.1 Timely Filing.
Provider shall submit all Claims that do not involve a third party payer, to Company within ninety (90) days of the date of service. [RFP SOW §6.1.2]

3.2 Cost Sharing and Patient Liability.
Provider shall not require any cost sharing or patient liability responsibilities for Covered Services except to the extent that cost sharing or patient liabilities are required for those services in accordance with law and the Agreement. [RFP SOW §3.2.15.3]

3.3 Third Party Liability.
Provider shall identify any third party liability coverage available to a Member, including Medicare and long-term care insurance, as applicable, and except as otherwise required, seek such third party liability payment before submitting Claims to Company. [RFP SOW §6.1.2]

3.4 Payment Net of Co-Payment.
Provider acknowledges and agrees that Company shall reduce the amount of payment it makes to Provider by the amount of the Member's Co-Payment obligation regardless of whether Provider has collected or waived the Co-Payment, except as provided in 42 C.F.R. §447.56(c). [RFP SOW §5.3.6]

3.5 Missed Appointments.
Provider shall not charge Members for missed appointments. [RFP SOW §3.2.15.3]

3.6 IDPH Participant Substance Use Disorder Services.

If and to the extent Provider provides substance use disorder services to IDPH Participants, Provider agrees to accept payment from the IDPH Participant according to the IDPH-approved siding fee schedule for such substance use disorder services. Providers billing and collection procedures for IDPH Participants shall be consistent with those established and provided by the IDPH. Provider agrees that services funded partially or completely by IDPH shall not be denied to a person because of the inability of the person or group to pay a fee for the service. Further, Provider shall not charge and IDPH Participant for missed appointments; provided, however, that Provider may charge the IDPH Participant a one-time no-show fee in an amount not to exceed that established by the IDPH. Provider acknowledges and agrees that IDPH funds are the payment of last resort for substance use disorder services provided to IDPH Participants and shall comply with IDPH and Company policies on IDPH eligibility for person with insurance coverage. [RFP SOW §5.5 & 13.6.4]

3.7 Provider Preventable Conditions.

Provider acknowledges and agrees that Company shall not make payment to Provider for a Provider Preventable Condition. This includes health-acquired conditions as identified by Medicare other than deep vein thrombosis and pulmonary embolism following total knee replacement or hip replacement surgery in pediatric and obstetric patients. Company shall also not make payment for wrong surgical or other invasive procedure on a patient or surgical, other invasive procedure performed on the wrong body part or wrong patient or any future additional to the list of non-reimbursable Provider Preventable Conditions. As a condition of payment under the Agreement, Provider agrees to comply with the reporting requirements for Provider Preventable Conditions found at 42 CFR §447.26(d). [RFP SOW §10.5]

4.0 GENERAL PROVISIONS

4.1 Debarred Individuals.

Provider represents and warrants that Provider is not and at no time has been (i) a person debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or (ii) an affiliate, as defined in the Federal Acquisition Regulation, of a person described in subsection (i) above. Provider shall immediately notify Company if at any time this representation and warranty is no longer accurate. [RFP SOW §2.6]

Exhibit D

Medicare Compliance Addendum

Without limiting any obligation of Provider under the Agreement, Provider agrees to the requirements set forth in this Addendum. Capitalized terms not otherwise defined herein, including within Schedule 1 attached hereto, shall have the meanings ascribed to them in the Agreement.

1. DESCRIPTION. This Addendum includes any Medicare plan(s) offered by Company to Medicare beneficiaries under a contract with the Centers for Medicare and Medicaid Services pursuant to Part C of Title XVIII of the Social Security Act ("Medicare Plans"). The Medicare Plans included in this Addendum do NOT include any Medicare Advantage plan(s) that the Company has deemed to be Medicare High Performance Network plans. From time to time Company and/or Payers may designate only certain Participating Providers to take part in the provider delivery network for a particular Product benefit plan(s).

2. PAYMENT.

A. In consideration of Provider's agreement to perform Covered Services in accordance with the Agreement, Provider shall be paid for Covered Services performed according to the terms of the applicable Service and Rate Schedule.

B. Company shall not pay any amounts beyond the amounts set forth in the applicable Service & Rate Schedule, including but not limited to any incentive payments that may be payable under traditional Medicare, except as expressly required by the Agreement or applicable law. Further, the Parties acknowledge and agree that payments under the Medicare program to providers, suppliers, and Medicare Advantage organizations may be adjusted as the result of legislation, regulation, executive order or other federal mandate ("Medicare Payment Adjustment"). Furthermore, any such Medicare Payment Adjustment could result in an increase or decrease in Medicare payments. In accordance with the terms of this Agreement, the Parties agree that, in the event of a Medicare Payment Adjustment, Company's payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. Company shall adjust payments under this Agreement for Covered Services rendered by Provider on and after the effective date of the Medicare Payment Adjustment, and shall continue to adjustment payments to Provider for until the earlier of (i) the Medicare Payment Adjustment is discontinued or (ii) is replaced by a subsequent Medicare Payment Adjustment.

C. Pursuant to Section 6.K. of this Addendum, Provider certifies that the diagnosis codes submitted to Company for Medicare Members that Company is required to submit to CMS will be accurate, complete and truthful ("Certification"). Provider acknowledges and agrees that Company may impose a penalty on Provider not to exceed five thousand dollars ($5,000) for each instance that Provider submits a diagnosis code to Company for a Medicare Member that does not comply with this Certification because the diagnosis code was not submitted in the format described in 42 C.F.R. § 422.310 or any subsequent or additional federal regulations. For purposes of this Section 2, "diagnosis code" shall mean an International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) code or its successor.

D. Federal laws and regulations limit the timeframe within which CMS may recover overpayments made to physicians, providers, and suppliers who submit claims to Medicare contractors (such as fiscal intermediaries, regional home health intermediaries, carriers, Medicare Administrative Contractors, and Durable Medical Equipment Medicare Administrative Contractors) for services provided or supplied to Medicare beneficiaries enrolled in Original Medicare ("Medicare Statute of Limitations"). If Company makes an overpayment or payment in error to Provider for Medicare Members, Company shall have the right to initiate overpayment recovery efforts within the same timeframe available to CMS under the Medicare Statute of Limitations; provided that no time limit shall apply to initiation of overpayment recovery efforts based on Company's reasonable suspicion of fraud or other intentional misconduct.

3. ASSIGNMENT. In addition to all other rights of Company under the Agreement, the Agreement (including, but not limited to, as it relates to the line(s) of business described in this Addendum) may be assigned by Company, at any time and from time to time, in whole or in part, to any other affiliate or successor in interest. At Company's option, the Agreement shall survive, without any other change in its terms, as a distinct, separate agreement with

Company for those products/lines of business designated by Company and in duplicate form as a separate, distinct participating provider agreement with the applicable affiliate(s)/successor(s) for the products/lines of business assigned to such entity(ies). In the event of any assignment under this paragraph, Company shall provide advance written notice to Provider. In the event of a conflict between this paragraph and any other provision of the Agreement, the terms of this paragraph shall supersede and prevail.

4. EFFECT OF TERMINATION. In the event this Addendum is terminated for any reason, such termination shall not constitute termination of any of Company's other products, plans or programs.

5. MEDICARE REQUIRED PROVISIONS. Provider agrees to comply with all of the provisions of Schedule 1, attached hereto and incorporated into this Addendum.

6. PROVIDER OBLIGATIONS.
A. Provision of Covered Services. Provider agrees to provide to Medicare Members the health care services for which Provider is licensed and customarily provides in accordance with accepted medical and surgical standards in the community. Provider shall make Covered Services available and accessible to Medicare Members, including telephone access to Provider, on a twenty-four (24) hours, seven (7) days per week basis.

B. Provider agrees that all Medicare Services and other activities performed by Provider under the Agreement will be consistent and comply with Company's obligations as a Medicare Advantage Organization under Company's contracts with CMS. Upon request, Provider shall immediately provide to Company any information that is required by Company to meet its reporting obligations to CMS, including without limitation, physician incentive plan information, if applicable. To the extent that Provider generates and/or compiles and provides any data to Company that Company, in turn, submits to CMS, Provider certifies, to the best of its knowledge and belief, that such data is accurate, complete and truthful. Provider agrees to cooperate with and participate in internal and external review procedures necessary to allow Company to process Medicare appeals and grievances in accordance with Medicare laws, regulations and CMS instructions.

C. Federal Fund Obligations. Provider understands and agrees that payments received by Company for the Medicare Plans from CMS pursuant to the Medicare Plan's contract with CMS are Federal funds. As a result, Provider, by entering into this Agreement and the terms of this Addendum, is subject to laws applicable to individuals/entities receiving Federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R. part 84, the Age Discrimination Act of 1975 as implemented by regulations at 45 C.F.R. part 91, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

D. Continuation of Services. In the event Company's Medicare contract for the Medicare Plans with CMS terminates or Company becomes insolvent, Provider shall continue to provide Covered Services to Medicare Members who are hospitalized through the later of: (a) the date for which premiums were paid, or (b) through the date of discharge. Provider is prohibited by law from billing Medicare Members for such Covered Services. This provision shall survive the termination of this Agreement or Addendum, regardless of the reason for termination, including the insolvency of Company, and shall supersede any oral or written agreement between Provider and a Medicare Member.

E. Policies, Programs & Procedures. Provider agrees to comply with Company's policies and procedures (which Company shall provide to Provider upon request) which operationalize many of the requirements of the Agreement, this Addendum, and the Medicare Program. Provider agrees to comply with Company's quality improvement, administrative processes and procedures, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures, and any other policies Company may implement, including amendments made to the above mentioned policies, procedures and programs from time to time. In the event that a Company policy or procedure conflicts with a provision in the Agreement, then the language in the Agreement (including all amendments, exhibits, and attachments thereto) shall govern.

F. Maintenance of Records. Provider shall preserve records applicable to Medicare Members or to Company's participation in the Medicare Program, for the longer of: (i) the period of time required by State and Federal law, or (ii) ten (10) years, whichever is longer. In addition, to the extent applicable to Provider, Provider, on behalf of itself and any Downstream Entities with whom Provider has contracted, agrees to comply with 42 C.F.R. §422.2480(c)

and to maintain all records containing data used by Company to calculate Medicare medical loss ratios ("MLRs") for Company's Medicare Products and/or evidence needed by Company and/or federal governmental authorities with jurisdiction to validate MLRs (collectively, "MLR Records") for a minimum of ten (10) years from the date such MLRs were reported by Company to CMS.

G. Subcontractors. Provider shall require all of its subcontractors, if any, to comply with all applicable Medicare laws, regulations and CMS instructions.

(1) Provider shall include in Provider's contracts with subcontractors all of the contractual and legal obligations required by Company or the laws, regulations, rules and directions of CMS, including, without limitation, that any delegated services or activities to be performed by subcontractor shall be consistent and comply with the obligations in the contract between CMS and Company governing Company's participation in the Medicare Program. To the extent CMS requires additional provisions to be included in such subcontracts, Provider shall amend its contracts accordingly.

(2) Provider shall ensure that any vendors, subcontractors or other such entities that have a need to know the terms of the Agreement also maintain the privacy and confidentiality of all financial terms of the Agreement.

(3) If Provider arranges for the provision of Covered Services from other health care providers for Medicare Members, such contracts shall be in writing and shall specify the delegated activities and reporting responsibilities, in addition to meeting the requirements described above. In the event that Company delegates to Provider the selection of providers, Company retains the right to approve, suspend or terminate such delegation. If Company delegates the selection of providers, Company will either review the credentials of medical professionals affiliated with Provider or Company will review, approve, and audit on an ongoing basis Provider's credentialing process. The term "Subcontractor" as used in this Section shall not refer to employees or other individuals that perform services on behalf of Provider for which Provider bills such services under this Agreement. Provider represents and warrants that such persons are subject to all terms and conditions of this Agreement and Provider shall provide written evidence of such as described in the Agreement.

H. Contracts with Excluded Entities. Provider understands and agrees that no person that provides health care services under this Agreement, or persons that provide utilization review, medical social work or administrative services in support of services billed under this Agreement by Provider may be an individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. Provider hereby certifies that no such excluded person will provide such services under this Agreement and no such excluded persons will be employed by or utilized by any Downstream Entity with which Provider contracts relating to the furnishing of these services to Medicare Members. In accordance with applicable laws, rules and regulations and the Compliance Program Guidelines, Provider agrees to review the Department of Health and Human Services ("HHS") Office of Inspector General List of Excluded Individuals and Entities and the General Service Administrative Excluded Parties Lists System (collectively, "Exclusion Lists") to ensure that Provider Related Parties are not included on such Exclusion Lists. Provider agrees to review the Exclusion Lists prior to initially hiring, appointing or contracting with any new Provider Related Party and at least once per month thereafter to confirm that Provider Related Parties are not included on such Exclusion Lists. Provider agrees that if a Provider Related Party appears on an Exclusion List and/or is excluded from participation in any federally-funded health program, Provider will immediately remove the Provider Related Party from any work related directly or indirectly to Company's Medicare Plans, and take all corrective actions required under applicable laws, rules or regulations. In the event Provider or any Provider Related Parties are listed in an Exclusion List after the Effective Date of this Addendum, Company shall have the right, in its sole discretion and judgment, to terminate this Addendum in accordance with the Agreement or to disqualify the listed person(s) from providing any part of the Covered Services. For the purpose of this section "Provider Related Parties" means Provider's permanent and temporary employees and Downstream Entities that are involved in the performance of Medicare Services.

I. Offshore Services. Provider is prohibited from using any individual or entity ("Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative or other individual or entity) to perform any services for Medicare Plans if the individual or entity is physically located outside of one of the fifty

United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands) ("Offshore Services"), unless Company, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity. Provider further agrees that Company has the right to audit any Offshore Entity prior to the provision of Offshore Services for Medicare Plans. Additionally, Provider acknowledges and agrees that Offshore Services that involve Medicare Member protected health information (PHI) are subject to CMS reporting within thirty (30) days of: (1) performing, or contracting with an Offshore Entity to perform, Offshore Services, and (2) any time Provider changes the Offshore Services that an Offshore Entity will perform.

J. Submission of Encounter Data. Provider hereby acknowledges that Company is required to provide CMS and other federal and state regulatory agencies and accrediting organizations with encounter data as requested by such agencies and organizations. Such data may include medical records and all other data necessary to characterize each encounter between Provider and a Medicare Member. Provider agrees to cooperate with Company and to provide Company with all such information in such form and manner as requested by Company. Provider agrees to immediately notify Company if any encounter data that Provider submitted to Company for Medicare Members is inaccurate, incomplete or erroneous, and cooperate with Company to correct erroneous encounter data to ensure Company's compliance with Medicare laws, rules and regulations and CMS instructions.

K. Certification of Data. Provider recognizes that as a Medicare Advantage organization, Company is required to certify the accuracy, completeness and truthfulness of data that CMS requests. Such data include encounter data, payment data, and any other information provided to Company by its contractors and subcontractors. Provider and its subcontractors, if any, hereby certify that any such data submitted to Company will be accurate, complete and truthful. Upon request, Provider shall make such certification in the form and manner prescribed by Company.

L. Medicare Member Complaints. Provider agrees to cooperate with Company in resolving any Medicare Member complaints related to coverage for the provision of Covered Services. Company will notify Provider as necessary concerning all Medicare Member complaints involving Provider. Provider shall, in accordance with the Provider's regular procedures, investigate such complaints and respond to Company in the required time. Provider shall use best efforts to resolve complaints in a fair and equitable manner.

M. Compliance Program and Anti-Fraud Initiatives. Provider shall (and shall cause its subcontractors to) institute, operate, and maintain an effective compliance program to detect, correct and prevent the incidence of non-compliance with CMS requirements and the incidence of fraud, waste and abuse (FWA) relating to the operation of Company's Medicare Program. Such compliance program shall be appropriate to Provider's or subcontractor's organization and operations and shall include: (a) written policies, procedures and standards of conduct articulating the entity's commitment to comply with federal and state laws, as well as providing mechanisms for employee/subcontractor use in adhering to the expectation that Provider and employee/subcontractor report potential non-compliance or FWA issues (internally and to Company, as applicable); (b) for all officers, directors, employees, contractors and agents of Provider or subcontractor, required participation in effective compliance and anti-fraud training and education that is consistent with guidance that CMS has or may issue with respect to compliance and anti-fraud and abuse initiatives, unless exempt from such training under relevant CMS regulations. This includes general compliance and FWA training completion, as well as code of conduct dissemination, initially within ninety (90) days of hire/contracting and at least annually thereafter; Provider and subcontractors, as applicable, may use Company's code and training or an equivalent; and (c) processes to oversee subcontractors to ensure their compliance with these requirements.

N. Marketing. Consistent with Federal laws, regulations, and agency requirements applicable to the Medicare Advantage Program, Provider shall not: (1) engage in any marketing or sales activities that could mislead or confuse Medicare beneficiaries, or (2) market or advertise non-health care related products to Medicare Members or prospective Medicare Members. Further, Provider shall at all times comply with the then current Medicare Marketing Guidelines.

O. Dual-Eligible Hold Harmless. Provider acknowledges and agrees that Medicare Members who are also enrolled in a State Medicaid plan ("Dual Eligible Members") are not responsible for paying to Provider any Copayments, Coinsurance or Deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when the State Medicaid plan is responsible for paying such Cost Sharing Amounts. Provider further agrees that they will

not collect Cost Sharing Amounts from Dual Eligible Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the Company's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts, or bill the applicable State Medicaid plan for the appropriate Cost Sharing Amounts owed by the State Medicaid plan.

7. COMPANY OBLIGATIONS.
A. Fee Schedule. Company shall arrange for Provider to be compensated for health care services rendered to Medicare Members in accordance with Section 2 of this Addendum.

B. Prompt Pay. In accordance with 42 C.F.R. § 422.520(a)(1), Company shall make best efforts to pay clean claims submitted by Provider for Covered Services provided to Medicare Members within thirty (30) calendar days of receipt. For purposes of this Addendum, the term "clean claim" shall have the meaning assigned in 42 C.F.R. §422.500.

8. GENERAL PROVISIONS
A. Termination. This Addendum may be terminated on its own without respect to the remainder of the Agreement with or without cause by either Party in accordance with the termination provisions of the underlying Agreement. This Addendum shall terminate automatically in the event that the underlying Agreement is terminated in accordance with the termination provisions of the Agreement.

B. Governing Law. This Addendum shall be governed by Federal laws, regulations, and agency requirements applicable to the Medicare Advantage Program. In the event that changes to the governing laws, regulations, or agency requirements applicable to the Medicare Advantage Program occur, the new law, regulation or agency requirement shall supersede to the extent required by any such later required changes.

C. All other terms and provisions of the Agreement not amended hereby shall remain in full force and effect, without modification. In the event of any inconsistency between the terms of this Addendum and the Agreement, the terms of this Addendum shall govern and control.

D. Survival. All provisions of this Addendum which by their nature should survive termination of Provider's provision of Medicare Services under this Agreement or termination of the Agreement as a whole, shall survive termination.

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Schedule 1

Medicare Required Provisions

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement between Company and Provider (referred to in this Schedule 1 as "FDR") not inconsistent herein shall remain in full force and effect. This Exhibit shall supersede and replace any inconsistent provisions to such Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

NOW, THEREFORE, the parties agree as follows:

A. Definitions:

1. Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

2. Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

3. Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

4. Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

5. First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

6. Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

7. Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

8. Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

9. Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

10. Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes

services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

B. <u>Required Provisions</u>:

FDR agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with Company's Affiliates included in this Agreement, (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)] and [42 CFR §423.505]

2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph 1 of this amendment directly from any first tier, downstream, or related entity. For records subject to review under paragraph 1, except in exceptional circumstances, CMS will provide notification to the MA organization that a direct request for information has been initiated. [42 C.F.R. §§ 422.504(i)(2)(ii) and (iii)]

3. FDR will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118] and [42 CFR §423.136]

4. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)] and [42 CFR §423.505(i)(3)(i)]

5. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. FDR may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

6. Any services or other activity performed in accordance with a contract or written agreement by FDR are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)] and [42 CFR §423.505(i)(3)(iii)]

7. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between the MA Organization/Physician and the provider. [42 C.F.R. §§ 422.520(b)(1) and (2)]
   See Section 7.b of the Addendum to which this Schedule 1 is attached.

8. FDR and any related entity, contractor or subcontractor will comply with all applicable Federal and Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)] and [42 CFR §423.505(i)(4)(iv)]

9. If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity:

[INFORMATIONAL NOTE: If there is no delegation of a specific activity or responsibility, please delete the related provision and replace with "None delegated".]

(i) The delegated activities and reporting responsibilities are specified as follows:

[List activities and reporting responsibilities or enter the section and name of the delegation or applicable agreement].

(ii) CMS and the MA organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.

(iii) The MA organization will monitor the performance of the parties on an ongoing basis.

[Enter any applicable section and name of the delegation or applicable agreement].

(iv) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.

[**Enter any applicable section and name of the delegation or applicable agreement].**

(v) If the MA organization delegates the selection of providers, contractors, or subcontractor, the MA organization retains the right to approve, suspend, or terminate any such arrangement.

[42 C.F.R. §§ 422.504(i)(4) and (5)]

In the event of a conflict between the terms and conditions above and the terms of a related agreement, the terms above control.

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Aetna Better Health of Iowa
Medicaid Physician Agreement

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Aetna Better Health of Iowa

Medicaid Physician Services Agreement Checklist

_____ **All** pages of this document must be printed and returned to Aetna Better Health (not just the signature pages).

_____ **Page 1**. The physician name that is filled in on the top of page one must match **exactly** with the name on the W9. Leave the effective date blank. This will be filled in by Aetna Better Health.

_____ **Page 20** must be signed by an authorized physician representative. In addition, all information listed below the signature line (TIN, NPI, and Reimbursement Address, etc) must be completed.

_____ **Provider Application**. The Aetna Better Health Provider Application must be completed and returned with the signed contract.

_____ **W9**. A W9 form must be returned with the contract. As indicated above, the name on the W9 must match exactly the name listed on pages 1 and 20 of the Agreement.

Please return all documents to:

Aetna Better Health of Iowa
Attn: Network Management
4320 NW 114th Street
Urbandale, IA 50322

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MEDICAID PHYSICIAN AGREEMENT

The term of this Medicaid Physician Agreement (the "Agreement") by and between Aetna Better Health of Iowa, an Iowa corporation on behalf of itself and its Affiliates (hereinafter "Company"), and _____ (hereinafter "Physician"), shall commence effective _____, 20___ [Date to be completed by Company] (the "Effective Date"). The Regulatory Compliance Addendum (Exhibit A) and Medicare Compliance Addendum (Exhibit D, including Schedule 1) attached to this Agreement, are expressly incorporated into this Agreement and are binding upon the Parties. In the event of any inconsistent or contrary language between the Addenda and any other part of this Agreement, including but not limited to exhibits, attachments or amendments, the Parties agree that the provisions of the Addenda shall prevail.

WHEREAS, Company administers Plans for Government Sponsors that provide access to health care services to Members or arranges for the provision of health care services to Members of Government Programs; and

WHEREAS, Company contracts with certain health care providers and facilities to provide access to such health care services to Members; and

WHEREAS, Physician provides health care services to patients within the scope of Physician's licensure or accreditation; and

WHEREAS, Company and Physician mutually desire to enter into an arrangement whereby Physician will become a Participating Provider and render health care services to Members; and

WHEREAS, in return for the provision of health care services by Physician, Company will pay Physician for Covered Services under the terms of this Agreement; and

WHEREAS, Physician understands and agrees that Government Sponsors or other government entities may require certain changes to the terms of this Agreement before Physician can provide services to Members under the terms of any Plans that are awarded, by the Government Sponsors, to Company.

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants, promises and undertakings herein, the sufficiency of which is hereby acknowledged, and intending to be legally bound hereby, the parties agree as follows:

1.0 DEFINITIONS

When used in this Agreement, all capitalized terms shall have the following meanings:

Affiliate. Any corporation, partnership or other legal entity (including any Plan) directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company.

Clean Claim. A claim that can be processed without obtaining additional information from the Physican who provided the service or from a third party, except that it shall not mean a claim submitted by or on behalf of a Physician who is under investigation for fraud or abuse, or a claim that is under review for medical necessity; provided, further, unless otherwise required by law or regulation, a claim which (a) is submitted within the proper timeframe as set forth in this Agreement and (b) has (i) detailed and descriptive medical and patient data, (ii) a corresponding referral (whether in paper or electronic format), if required for the applicable claim, (iii) whether submitted via an electronic transaction using permitted standard code sets (e.g., CPT-4, ICD-9, HCPCS and successor codes) as required by the applicable Federal or state regulatory authority (e.g., U.S. Dept. of Health & Human Services, U.S. Dept. of Labor, state law or regulation) or otherwise, all the data elements of the UB-04 or CMS-1500 (or successor standard) forms (including but not limited to Member identification number, national provider identifier ("NPI"), date(s) of service, complete and accurate breakdown of services), and (c) does not involve coordination of benefits, and (d) has no defect or error (including any new procedures with no CPT code, experimental procedures or other circumstances not contemplated at the time of execution of this Agreement) that prevents timely adjudication.

Coinsurance. A payment a Member is required to make under a Plan which is determined as a percentage of the lesser of: (a) the rates established under this Agreement; or (b) Physician's usual, customary and reasonable billed charges.

Confidential Information. Any information that identifies a Member and is related to the Member's participation in a Plan, the Member's physical or mental health or condition, the provision of health care to the Member or payment for the provision of health care to the Member. Confidential Information includes, without limitation, "individually identifiable health information," as defined in 45 C.F.R. § 160.103 and "non-public personal information" as defined in laws or regulations promulgated under the Gramm-Leach-Bliley Act of 1999.

Copayment. A charge required under a Plan that must be paid by a Member at the time of the provision of Covered Services, or at such other time as determined by Physician and which is expressed as a specific dollar amount.

Covered Services. Those health care services for which a Member is entitled to receive coverage under the terms and conditions of a Plan. The Parties agree that Company is obligated to pay for only those Covered Services that are determined to be medically necessary, as determined in accordance with the Member's applicable Plan.

Covering Physician. A Participating Provider designated by Physician to provide Covered Services to Members when Physician is unavailable (e.g. out of the office or on vacation).

Deductible. An amount that a Member must pay for Covered Services during a specified coverage period in accordance with the Member's Plan before benefits will be paid.

Effective Date. Defined in first paragraph of this Agreement.

Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, her pregnancy or health or the health of her fetus) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part; or such other definition as may be required by applicable law.

Emergency Services. Covered Services furnished by a qualified provider and necessary to evaluate or stabilize an Emergency Medical Condition.

Government Programs. Plans operated and/or administered by Company pursuant to a State Contract.

Government Sponsor. A state agency or other governmental entity authorized to offer, issue and/or administer one or more Plans, and which, to the extent applicable, has contracted with Company to administer all or a portion of such Plan(s).

Material Change. Any change in Policies that could reasonably be expected, in Company's determination, to have a material adverse impact on (i) Physician's reimbursement for Physician Services, (ii) administration of Physician's practice or (iii) the delivery of care or services provided under this Agreement and the State Contract.

Medically Necessary or Medical Necessity. Health care services that a physician or other applicable health care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Fore these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty

society recommendation and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member. An individual covered by or enrolled in a Plan.

Participating Provider. Any physician, hospital, hospital-based physician, skilled nursing facility, mental health and/or substance abuse professional (which shall include psychiatrists, psychologists, social workers, psychiatric nurses, counselors, family or other therapists or other mental health/substance abuse professionals), or other individual or entity involved in the delivery of health care or ancillary services who or which has entered into and continues to have a current valid contract with Company to provide Covered Services to Members, and, where applicable, has been credentialed by Company or its designee consistent with the credentialing policies of Company or its designee, as applicable. Certain categories of Participating Providers may be referred to herein more specifically as, e.g., "Participating Physicians" or "Participating Hospitals."

Party. Company or Physician, as applicable. Company and Physician may be referred to collectively as the "Parties."

Physician. Defined in first paragraph of this Agreement.

Physician Services. Defined in Section 2.1 of this Agreement.

Plan. A Member's health care benefits as set forth in the State Contract. Such Plans are listed in the **Program Participation Schedule** attached hereto and made a part hereof.

Policies. The policies and procedures promulgated by Company which relate to the duties and obligations of the Parties under the terms of this Agreement, including, but not limited to: (a) quality improvement/management; (b) utilization management, including, but not limited to, precertification of elective admissions and procedures, concurrent review of services and referral processes or protocols; (c) pre-admission testing guidelines; (d) claims payment review; (e) member grievances; (f) Physician credentialing; (g) electronic submission of claims and other data required by Company; and (h) any applicable participation criteria required by the State in connection with the Government Programs. Policies also include those policies and procedures set forth in the Company's and/or Government Sponsor's manuals (as modified from time to time) as Company determines appropriate in its sole discretion; clinical policy bulletins made available via Company's internet web site; and other policies and procedures, whether made available via a password-protected web site for Participating Physicians (when available), by letter, newsletter, electronic mail or other media.

Post-Stabilization Care Services. Covered Services relating to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, under circumstances defined in federal regulations, to improve or resolve the Member's condition.

Primary Care Provider ("PCP"). A Participating Physician whose area of practice and training is family practice, general medicine, internal medicine or pediatrics, or who is otherwise designated as a Primary Care Physician by Company, and who has agreed to provide primary care services and to coordinate and manage all Covered Services for Members who have selected or been assigned to such Participating Physician, if the applicable Plan provides for a Primary Care Physician.

Proprietary Information. Any and all information, whether prepared by a Party, its advisors or otherwise, relating to such Party or the development, execution or performance of this Agreement whether furnished prior to or after the Effective Date. Proprietary Information includes but is not limited to, with respect to Company, the development of a pricing structure, (whether written or oral) all financial information, rate schedules and financial terms which relate to Physician and which are furnished or disclosed to Physician by Company. Notwithstanding the foregoing, the following shall not constitute Proprietary Information:

(a) information which was known to a receiving Party (a "Recipient") prior to receipt from the other Party (a "Disclosing Party") (as evidenced by the written records of a Recipient);

(b) information which was previously available to the public prior to a Recipient's receipt thereof from a Disclosing Party;

(c) information which subsequently became available to the public through no fault or omission on the part of a Recipient, including without limitation, the Recipient's officers, directors, trustees, employees, agents, contractors and other representatives;

(d) information which is furnished to a Recipient by a third party which a Recipient confirms, after due inquiry, has no confidentiality obligation, directly or indirectly, to a Disclosing Party; or

(e) information which is approved in writing in advance for disclosure or other use by a Disclosing Party.

Specialty Program. A program for a targeted group of Members with certain types of illnesses, conditions, cost or risk factors.

Specialty Program Providers. Those hospitals, physicians and other providers that have been identified or designated by Company or the Government Sponsor to provide Covered Services associated with a Specialty Program.

State Contract. Company's contract(s) with Government Sponsors to administer Plans or Government Programs identified in the **Program Participation Schedule**.

2.0 PHYSICIAN SERVICES AND OBLIGATIONS

2.1 Provision of Services.
Physician shall provide to Members those Covered Services which are within the scope of Physician's license and certification to practice ("Physician Services"). Physician shall also, as applicable, arrange and coordinate the overall provision of Covered Services to Members under the terms and conditions of the Member's applicable Plan. Physician shall provide or arrange for the provision of Covered Services, including, without limitation, Emergency Services, regardless of whether Physician has previously seen or treated the Member. Physician may not provide any Covered Services to Members unless and until Physician has been fully credentialed and approved by Company or its designee.

2.2 Non-Discrimination and Equitable Treatment of Members.
Physician agrees to provide Physician Services to Members with the same degree of care and skill as customarily provided to Physician's patients who are not Members, according to generally accepted standards of physician practice. Physician and Company agree that Members and non-Members should be treated equitably. Physician agrees not to discriminate against Members on the basis of race, ethnicity, gender, creed, ancestry, lawful occupation, age, religion, marital status, sexual orientation, mental or physical disability, medical history, color, national origin, place of residence, health status, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment for services, cost or extent of Physician Services required, or any other grounds prohibited by law or this Agreement and will abide by Company's cultural competency Policies.

2.3 Federal Law.
Company is a Federal contractor and an Equal Opportunity Employer which maintains an Affirmative Action Program. To the extent applicable to Physician, Physician, on behalf of itself and any subcontractors, agrees to comply with the following, as amended from time to time: Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq., and regulations promulgated thereunder, Executive Order 11246, the Vietnam Era Veterans Readjustment Act of 1974, the Drug Free Workplace Act of 1988, Section 503 of the Rehabilitation Act of 1973, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") administrative simplification rules at 45 CFR parts 160, 162, and 164, the Americans with Disabilities Act of 1990, Federal laws, rules and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (Section

1128B(b) of the Social Security Act), and any similar laws, regulations or other legal mandates applicable to recipients of federal funds and/or transactions under or otherwise subject to any government contract of Company.

2.4 Referrals.
To the extent required by the terms of the applicable Plan, Physician shall refer or admit Members only to Participating Providers for Covered Services, and shall furnish such Participating Providers with complete information on treatment procedures and diagnostic tests performed prior to such referral or admission. In addition, to the extent possible, Physician shall refer Members with out of network benefits, if any, to Participating Providers. Physician shall be liable for any expenses resulting from a referral to a non-Participating Provider that Company did not pre-certify in advance, as permitted by applicable law.

2.5 Physician Representations.

2.5.1 General Representations. Physician represents, warrants and covenants, as applicable, that: (a) it has, and shall maintain throughout the term of this Agreement all appropriate license(s) and certification(s) mandated by governmental regulatory agencies, including without limitation DEA certification, certification to participate in the Medicaid and Medicare programs, and an unrestricted license to practice medicine in the state(s) in which Physician maintains offices and provides Covered Services to Members; (b) it is, and will remain throughout the term of this Agreement, in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided hereunder, including, without limitation, statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, self-referral, false claims and prohibition of kickbacks; (c) Physician has and shall maintain throughout the term of this Agreement unrestricted hospital privileges at a Participating Hospital; (d) this Agreement has been executed by its duly authorized representative; (e) executing this Agreement and performing its obligations hereunder shall not cause Physician to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed; and (f) it is not excluded, debarred or suspended from participation in any government-sponsored program including, but not limited to, Government Programs, Medicare and Medicaid.

2.5.2 Qualified Personnel. Physician also represents that Physician has established an ongoing quality assurance/assessment program which includes, but is not limited to, credentialing of employees and subcontractors. Physician shall supply to Company the relevant documentation, including, but not limited to, internal quality assurance/assessment protocols, state licenses and certifications, Federal agency certifications and/or registrations upon request. Physician further represents that all personnel employed by, associated or contracted with Physician who treat Members: (a) are and shall remain throughout the term of this Agreement appropriately licensed and/or certified and supervised (when and as required by state law), and qualified by education, training and experience to perform their professional duties; and (b) shall act within the scope of their licensure or certification, as the case may be. Physician is prohibited from using any individual or entity ("Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative or other individual or entity) to perform any services for Plans if the individual or entity is physically located outside of one of the fifty United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands), unless Company, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity. Physician further agrees that Company has the right to audit any Offshore Entity prior to the provision of services for Plans. Company may audit Physician's compliance with this section upon prior written notice. Company may audit Physician's compliance with this section upon prior written notice.

2.5.3 Government Program Representations. Company has or shall seek contracts to serve beneficiaries of Government Programs. To the extent Company participates in such Government Programs, Physician agrees, on behalf of itself and any subcontractors of Physician acting on behalf of Physician, to be bound by all rules and regulations of, and all requirements applicable to, such Government Programs. Physician acknowledges and agrees that all provisions of this Agreement shall apply equally to any employees, independent contractors and subcontractors of Physician who provide or may provide Covered Services to Members of Government Programs, and Physician represents and warrants that

Physician shall cause such employees, independent contractors and subcontractors to comply with this Agreement, the State Contract, and all applicable laws, rules and regulations and perform all requirements applicable to Government Programs. Any such subcontract or delegation shall be subject to prior written approval by Company. With respect to Members of Government Programs, Physician acknowledges that compensation under this Agreement for such Members constitutes receipt of Federal funds. Physician agrees that all services and other activities performed by Physician under this Agreement will be consistent and comply with the obligations of Company and/or Government Sponsor under its contract(s) with the Centers for Medicare and Medicaid Services (CMS), and any applicable state regulatory agency, to offer Government Program. Physician further agrees to allow Government Sponsor, CMS, any applicable state regulatory agency, and Company to monitor Physician's performance under this Agreement on an ongoing basis in accordance with applicable laws, rules and regulations. Physician acknowledges and agrees that Company may only delegate its activities and responsibilities under the State Contract or any Company contract(s) with Government Sponsor, CMS and any applicable regulatory agency, to offer Government Program in a manner consistent with applicable laws, rules and regulations, and that if any such activity or responsibility is delegated by Company to Physician, the activity or responsibility may be revoked if Government Sponsor, CMS or Company determine that Physician has not performed satisfactorily. Upon request, Physician shall immediately provide to Company any information that is required by Company to meet its reporting obligations to CMS, including without limitation, physician incentive plan information, if applicable. To the extent that Physician generates and/or compiles and provides any data to Company that Company, in turn, submits to CMS, Physician certifies, to the best of its knowledge and belief, that such data is accurate, complete and truthful.

2.5.4 Government Program Requirements. Physician hereby agrees to perform its obligations under this Agreement in accordance with the terms and conditions set forth in Exhibits A and D.

2.5.5 Suspension or Debarment. Physician represents, warrants and covenants, as applicable, that it:

a. Has not within a three year period preceding the proposal submission been convicted or had a civil judgment rendered against him/her/it for commission of fraud or criminal offense in performing a public transaction or contract (local, state or federal) or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property; and

b. Is not presently indicted for or otherwise criminally or civilly charged by a governmental entity with the commission of any of the above offenses; and

c. Has not within a five year period preceding execution of this Agreement had one or more public transactions terminated for cause or fault; and

d. Is not excluded, debarred or suspended from participation in any government-sponsored program including, but not limited to, Government Programs, Medicare or the Medicaid program in any state; and

e. Will immediately report any change in the above status to Company; and

f. Will maintain all appropriate licenses to perform its duties and obligations under the Agreement.

2.6 Physician's Insurance.

During the term of this Agreement, Physician agrees to procure and maintain such policies of general and professional liability and other insurance, or a comparable program of self-insurance, at minimum levels as required by state law or, in the absence of a state law specifying a minimum limit, an amount customarily maintained by Physician in the state or region in which the Physician operates. Such insurance coverage shall cover the acts and omissions of Physician as well as those Physician's agents and employees. Physician agrees to deliver certificates of insurance or other documentation as appropriate to show evidence of such

coverage to Company upon request. Physician agrees to make best efforts to provide to Company at least thirty (30) days advance notice, and in any event will provide notice as soon as reasonably practicable, of any cancellation or material modification of said policies.

2.7 Product Participation.

Physician agrees to participate in the Plans and other health benefit programs listed on the **Program Participation Schedule**. Company reserves the right to introduce and designate Physician's participation in new Plans, Specialty Programs and other programs during the term of this Agreement and will provide Physician with written notice of such new Plans, Specialty Programs and other programs and the associated compensation. To the extent that Company establishes and/or participates in a provider Pay-for-Performance incentive program or Performance Improvement Programs, Physician agrees to comply with and participate in such program.

Nothing herein shall require that Company identify, designate or include Physician as a preferred participant in any specific Plan for which Company provides incentives based upon the use of selected Participating Physicians, Specialty Program or other program; provided, however, Physician shall accept compensation in accordance with this Agreement for the provision of any Covered Services to Members under a Plan, Specialty Program or other program in which Physician has agreed to participate hereunder.

2.8 Consents to Release Medical Information.

Physician covenants that it will obtain from Members to whom Physician Services are provided, any necessary consents or authorizations to the release of Information and Records to Company, Government Sponsors, their agents and representatives in accordance with any applicable Federal or state law or regulation or this Agreement.

2.9 Encounter Data.

For those services for which Physician is compensated, Physician agrees to provide Company with encounter data by type of Physician Service rendered to Members in the form and manner as specified by Company. There shall be no restrictions on Company's use of such encounter data. Furthermore, Company is under no obligation to return such encounter data to Physician.

Company is or may be required to obtain encounter data from Physician for Members, and Physician agrees to provide complete and accurate encounter data to Company for Members that conforms to all standards and requirements set forth in applicable laws, rules and regulations, Government Sponsor and/or CMS instructions that apply to encounter data. Physician certifies, based on best knowledge, information and belief, that any encounter data that Physician submits to Company for Members is accurate, complete and truthful. Physician agrees to immediately notify Company if any encounter data that was submitted to Company for Members is erroneous, and follow procedures established by Company to correct erroneous encounter data to ensure Company's compliance with applicable laws, rules and regulations, and Government Sponsor and CMS instructions.

Physician further agrees to maintain accurate, legible and complete medical record documentation for all encounter data submitted to Company for Members in a format that meets all standards and requirements set forth in applicable laws, rules, regulations, and/or Government Sponsor and CMS instructions, and allows any governmental authorities with jurisdiction or their designees ("Government Officials") to, in part: (1) confirm that the appropriate diagnoses codes and level of specificity are documented ; (2) verify the date of service is documented and within the encounter data collection period; and (3) confirm that the appropriate provider's signature and credentials are present ("Medical Records").

Physician agrees to provide Company and Government Officials, or their designees, with medical records and any other information or documentation required by Government Officials for the validation of encounter data ("Audit Data"). Physician agrees to provide Company with Audit Data within the timeframe established by Company to ensure Company's compliance with deadlines imposed by Government Officials for the submission of Audit Data. In the event that Government Sponsor or CMS conducts a review that includes the validation of encounter data submitted by Physician, Company will submit to Physician, as applicable, a copy

of the Government Sponsor or CMS written notice of such review, along with a written request from Company for Audit Data.

2.10 Administrative Obligations of Primary Care Physicians.
Each Participating Physician who is a Primary Care Physician shall comply with the following to the extent required under the terms of the applicable Plan:

2.10.1 Coordination of Care. A Primary Care Physician shall arrange and coordinate the overall provision of Covered Services to Members under the terms and conditions of the Member's applicable Plan. A Primary Care Physician shall provide or arrange for the provision of Covered Services, including, without limitation, Emergency Services, regardless of whether a Participating Physician has previously seen or treated the Member.

2.10.2 Referrals. To the extent required by the terms of the applicable Plan, Participating Physicians who are Primary Care Physicians shall refer or admit Members only to Participating Providers for Covered Services, and shall furnish such Participating Providers with complete information on treatment procedures and diagnostic tests performed prior to such referral or admission. In addition, to the extent possible, Physicians who are Primary Care Physicians shall refer Members with out-of-network benefits, if any, to Participating Providers.

2.10.3 Closed Panel. Participating Physicians and Company agree that a broad selection of physicians is important to Members and that Members expect physicians listed in Company's directories to be available to them. Accordingly, only upon at least ninety (90) days prior written notice with good cause acceptable to Company may a Participating Physician prospectively decline to accept new Members as patients. To prevent discrimination against Company or its Members, for such time as a Participating Physician declines to accept new Members as patients, such Participating Physicians shall not accept as patients additional members from any entity or organization which competes with Company.

2.11 Administrative Obligations of Participating Physicians Other than Primary Care Physicians.
A Participating Physician who is not a Primary Care Physician shall: (a) except for Emergency Services, to the extent a referral is required by the applicable Plan, provide Covered Services to Members only upon prior referral of such patients by a Primary Care Physician to said Participating Physician on prescribed forms or by electronic means as instructed by Company; (b) except for Emergency Services and Post-Stabilization Care Services, to the extent required by the applicable Plan, render services to Members only at those inpatient, extended care, and ancillary service facilities which have been approved in advance by Company; and (c) promptly submit a report on the treatment of each Member to the referring Primary Care Physician, if applicable. Except for Emergency Services, payment for retroactive referrals shall be subject to adjustment or denial by Company.

3.0 COMPANY OBLIGATIONS

3.1 Company's Covenants.
Company or Government Sponsors shall provide Members with a means to identify themselves to Physician (e.g., identification cards), explanation of Physician payments, a general description of products, a listing of Participating Physicians, and timely notification of Material Changes in this information. Company shall provide Physician with a means to check eligibility. Company shall include Physician in the Participating Provider directory or directories for the Plans, Specialty Programs and products in which Physician is a Participating Physician, including when Physician is designated as preferred participant, and shall make said directories available to Members. Company reserves the right to determine the content of Physician directories.

3.2 Company Representations.
Company represents and warrants that: (a) this Agreement has been executed by its duly authorized representative; and (b) executing this Agreement and performing its obligations hereunder shall not cause

Company to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

The parties acknowledge that one or more state governmental authorities may recommend or require that various Company agreements, including this Agreement, be executed prior to the issuance to Company of one or more approvals, consents, licenses, permissions or other authorizations from governmental authorities with jurisdiction over the subject matter of this Agreement, or which Company deems to be necessary or desirable in its sole discretion (collectively, a "License"). Physician agrees that all Company obligations to perform, and all rights of Physician, under this Agreement are expressly conditioned upon the receipt of all Licenses. Failure of Company to obtain any License shall impose no liability on Company under this Agreement.

3.3 Company's Insurance.
Company at its sole cost and expense agrees to procure and maintain such policies of general and/or professional liability and other insurance (or maintain a self-insurance program) as shall be necessary to insure Company and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any service by Company under this Agreement and the administration of Plans.

4.0 CLAIMS SUBMISSIONS, COMPENSATION AND MEMBER BILLING

4.1 Claim Submission and Payment.

4.1.1 Physician Obligation to Submit Claims. Physician agrees to submit Clean Claims to Company for Physician Services rendered to Members. Physician agrees to submit claim and encounter data related to a Member enrolled in a Government Program in the form and manner as specified by Company, and, Physician certifies that any such data is accurate, complete and truthful. Physician will make best commercial efforts to submit a minimum of eighty-five percent (85%) of its Member claims electronically to Company. Physician represents that, where necessary, it has obtained signed assignments of benefits authorizing payment for Physician Services to be made directly to Physician. For claims Physician submits electronically, Physician shall not submit a claim to Company in paper form unless Company requests paper submissions or fails to pay or otherwise respond to electronic claims submission in accordance with the time frames required under this Agreement or applicable law or regulation. Physician agrees that Company, or the applicable Government Sponsor, will not be obligated to make payments for billings received more than one hundred and twenty (120) days (or such other period required by applicable state law or regulation) from (a) the date of service or, (b) the date of receipt of the primary payer's explanation of benefits when Company is the secondary payer. Company may waive this requirement if Physician provides notice to Company, along with appropriate evidence, of other extraordinary circumstances outside the control of Physician that resulted in the delayed submission. In addition, unless Physician notifies Company of its payment disputes within one hundred eighty (180) days, or such other time as required by applicable state law or regulation, of receipt of payment from Company, such payment will be considered full and final payment for the related claims. If Physician does not timely bill Company or Government Sponsors, or dispute any payment, timely as provided in this Section 4.1.1, Physician's claim for payment will be deemed waived and Physician will not seek payment from Government Sponsors, Company or Members. Physician shall pay on a timely basis all Participating Providers, employees, independent contractors and subcontractors who render Covered Services to Members of Company's Plans for which Physician is financially responsible pursuant to this Agreement.

Physician agrees to permit claim editing to the primary procedure those services considered part of, incidental to, or inclusive of the primary procedure and make other adjustments for inappropriate billing or coding (e.g., rebundling, duplicative procedures or claim submissions, mutually exclusive procedures, gender/procedure mismatches, age/procedure mismatches). To the extent Physician is billing on a CMS 1500, as of the Effective Date, in performing adjustments for inappropriate billing or coding, Company utilizes a commercial software package (as modified by Company for all Participating Physicians in the ordinary course of Company's business) which commercial software

package relies upon Government Programs and other industry standards in the development of its rebundling logic.

Subject to applicable law: (i) Company may update internal payment systems in response to additions, deletions, and changes to Government Sponsor, CMS, or other industry source codes without obtaining any consent from Physician or any other party, and Company will provide, at the written request of Physician, a copy of the fee schedule in effect at the time of such request; (ii) Company shall not be responsible for communicating such routine changes of this nature, and will update any applicable payment schedules on a prospective basis within ninety (90) days from the date of publication or such longer period as Company determines appropriate in its sole discretion; and (iii) Company shall have no obligation to retroactively adjust claims.

4.1.2 Company Obligation to Pay for Covered Services. Company shall make payments to Physican for Covered Services on a timely basis consistent with the claims payment procedure described at 42 U.S.C. § 1396a(a)(37)(A). Company agrees to pay Physician for non-capitated Covered Services rendered to Members according to the lesser of (i) Physician's actual billed charges or (ii) the rates set forth in the **Services and Compensation Schedule**, attached hereto and made a part hereof. Company must pay ninety percent (90%) of all such Clean Claims from Physician within thirty (30) days following actual receipt; provided, further, Company must pay ninety-nine percent (99%) of all Clean Claims from Physician within ninety (90) days following actual receipt. Physician will make best commercial efforts to utilize online explanation of benefits or electronic remittance of advice (or combination thereof) and electronic funds transfer in lieu of receiving paper equivalents to the extent such services are available from Company. Company reserves the right to recoup any overpayment or payment made in error (e.g., a duplicate payment or payment for services rendered by Physician to a patient who was not a Member and amounts identified through routine investigative reviews of records or audits) against any other monies due to Physician under this Agreement.

In the event that Physician identifies any overpayments by Company, Physician shall, as required under Section 6402(a) of the Patient Protection and Affordable Care Act, report and return any and all such overpayments to Company within sixty (60) days of Physician's identification of any and all such overpayments. In addition, when reporting and returning any such overpayments by Company, Physician must provide Company with a written reason for the overpayment (e.g., excess payment under coordination of benefits, etc.).

To the extent, if any, that the compensation under certain Plans is in the form of capitation payments or a case-based rate methodology, Physician acknowledges the financial risks to Physician of this arrangement and has made an independent analysis of the adequacy of this arrangement. Physician, therefore, agrees and covenants not to bring any action asserting the inadequacy of these arrangements or that Physician was in any way improperly induced by Company to accept the rate of payment, including, but not limited to, causes of actions for damages, rescission or termination alleging fraud or negligent misrepresentation or improper inducement. Furthermore, to the extent that the compensation under certain Plans is in the form of capitation payments or a case-based methodology and Physician utilizes the services of a Covering Physician, Physician agrees to hold Company, Affiliates, Government Sponsors, Members and Payers harmless against any and all claims by such Covering Physician related to or arising out of payment for Covered Services rendered to Members. Physician understands that if Company makes payment to such Covering Physician under the circumstances described above, Company may recoup against future payments the amount paid to such Covering Physician. Notwithstanding anything in this Agreement to the contrary, during such time as Physician is a member of a Group, Physician agrees to seek compensation solely from Group for those Covered Services provided to Members and for which Group is compensated by Company on behalf of Physician, and Physician shall in no event bill Company, its Affiliates, Government Sponsor, Payers or Members for any such Covered Services (except for the collection of Copayments, Coinsurance, Deductibles in accordance with Section 3.2).

Complaints or disputes concerning payments for the provision of services as described in this Agreement shall be subject to the Company's grievance resolution system.

4.1.3 Eligibility Determinations. Company shall have the right to recover payments made to Physician if the payments are for services provided to an individual who is later determined to have been ineligible based upon information that is not available to Company at the time the service is rendered or authorization is provided

4.1.4 Utilization Management. Company utilizes systems of utilization review/quality improvement/peer review to promote adherence to accepted medical treatment standards and to encourage Participating Physicians to minimize unnecessary medical costs consistent with sound medical judgment and in accordance with applicable law. To further this end, Physician agrees, consistent with sound medical judgment and in accordance with applicable law:

(a) To participate, as requested, and to abide by Company's utilization review, patient management, quality improvement programs, and all other related programs (as modified from time to time) and decisions with respect to all Members.

(b) To comply with Company's pre-certification and utilization management requirements for all elective admissions and other Covered Services.

(c) To regularly interact and cooperate with Company's nurse case managers.

(d) To utilize Participating Physicians to the fullest extent possible, consistent with sound medical judgment.

(e) To abide by all Company's credentialing criteria and procedures, including site visits and medical chart reviews, and to submit to these processes biannually, annually, or otherwise, when applicable.

(f) To obtain advance authorization from Company prior to any non-Emergency Service admission, and in cases where a Member requires an Emergency Service hospital admission or Post-stabilization Care Services, to notify Company, both in accordance with Company's Policies then in effect.

Except when a Member requires Emergency Services, Physician agrees to comply with any applicable precertification and/or referral requirements under the Member's Plan prior to the provision of Physician Services. Physician agrees to notify Company of all admissions of Members, and of all services for which Company requires notice, upon admission or prior to the provision of such services. For those Members who require services under a Specialty Program, Physician agrees to work with Company in transferring the Member's care to a Specialty Program Physician.

4.2 Coordination of Benefits

Except as otherwise required under applicable Federal, state law or regulation or a Plan, when Company or a Government Sponsor is secondary payer under applicable coordination of benefit principles, and payment from the primary payer is less than the compensation payable under this Agreement without coordination of benefits, then Company or Government Sponsor will pay Physician the lesser of (i) the copayment, coinsurance and deductible amount for the Covered Services as reported on the explanation of benefits of the primary payer, or (ii) the amount of the difference between the amount paid by the primary payer and the compensation payable under this Agreement, absent other sources of payment. Notwithstanding any other provision of this paragraph, if payment from the primary payer is greater than or equal to the compensation payable under this Agreement without coordination of benefits, neither Company, Government Sponsor nor the applicable Member (in accordance with Section 4.3.2 below) shall have any obligation to Physician. Notwithstanding anything to the contrary in this section, in no event shall Physician collect more than Medicare allows if Medicare is the primary payer. Medicaid is never the primary payer.

4.3 Member Billing.

4.3.1 Permitted Billing of Members. Physician may bill or charge Members only in the following circumstances: (a) applicable Copayments, Coinsurance and/or Deductibles, if any, not collected at the time that Covered Services are rendered; and (b) for services that are not Covered Services only if: (i) the Member's Plan provides and/or Company confirms that the specific services are not covered; (ii) the Member was advised in writing prior to the services being rendered that the specific services may not be Covered Services; and (iii) the Member agreed in writing to pay for such services after being so advised. Physician acknowledges that Company's denial or adjustment of payment to Physician based on Company's performance of utilization management as described in Section 4.1.3 or otherwise is not a denial of Covered Services under this Agreement or under the terms of a Plan, except if Company confirms otherwise under this Section 4.3. Physician may bill or charge individuals who were not Members at the time that services were rendered.

4.3.2 Holding Members Harmless. Physician hereby agrees that in no event, including, but not limited to the failure, denial or reduction of payment by Company, insolvency of Company or breach of this Agreement, shall Physician bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse (i) against Members or persons acting on their behalf (other than Company) or (ii) any settlement fund or other *res* controlled by or on behalf of, or for the benefit of, a Member for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance, Deductibles made in accordance with the terms of the applicable Plan. Physician further agrees that this Section 4.3.2: (a) shall survive the expiration or termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) supersedes any oral or written contrary agreement or waiver now existing or hereafter entered into between Physician and Members or persons acting on their behalf.

4.3.3 Cost Sharing Protections for Dual Eligible Members. Physician acknowledges and agrees that Medicare Members who are also enrolled in a State Medicaid plan ("Dual Eligible Members") are not responsible for paying to Physician any Copayments, Coinsurance or Deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when the State Medicaid plan is responsible for paying such Cost Sharing Amounts. Physician further agrees that they will not collect Cost Sharing Amounts from Dual Eligible Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the Company's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts, or bill the applicable State Medicaid plan for the appropriate Cost Sharing Amounts owed by the State Medicaid plan.

To protect Members, Physician agrees not to seek or accept or rely upon waivers of the Member protections provided by this Section 4.3.

5.0 COMPLIANCE WITH POLICIES

5.1 Policies.

Physician agrees to accept and comply with Policies of which Physician knows or reasonably should have known (e.g., clinical policy bulletins or other Policies made available to Physician). Physician will utilize the electronic real time HIPAA compliant transactions, including but not limited to, eligibility, precertification and claim status inquiry transactions to the extent such electronic real time features are utilized by Company. Company may at any time modify Policies. Company will provide notice by letter, newsletter, electronic mail or other media, of Material Changes. Failure by Physician to object in writing to any Material Change within thirty (30) days following receipt thereof constitutes Physician's acceptance of such Material Change. In the event that Physician reasonably believes that a Material Change is likely to have a material adverse financial impact upon Physician's practice, Physician agrees to notify Company in writing, specifying the specific bases demonstrating a likely material adverse financial impact, and the Parties will negotiate in good faith an appropriate amendment, if any, to this Agreement. Notwithstanding the foregoing, at Company's discretion, Company may modify the Policies to comply with applicable law or regulation, or any order or directive of any governmental agency, without the consent of Physician, and the Policies shall be deemed to be automatically amended to conform with all laws and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over this Agreement. Physician agrees that noncompliance with any requirements of this Section 5.1 or any Policies will relieve Company or

Government Sponsors and Members from any financial liability for the applicable portion of the Physician Services.

5.2 Notices and Reporting.

To the extent neither prohibited by law nor violative of applicable privilege, Physician agrees to provide notice to Company, and shall provide all information reasonably requested by Company regarding the nature, circumstances, and disposition, of: (a) any litigation or administrative action brought against Physician or any of its employees or affiliated providers which is related to the provision of health care services and could have a material impact on the Physician Services provided to Members; (b) Company requirements regarding reporting of self-referrals, loss of licensure or accreditation, and claims by governmental agencies or individual regarding fraud, abuse, self-referral, false claims, or kickbacks; and (c) any material change in services provided by Physician or licensure status related to such services. Company and Physician agree to be mutually committed to promoting Member safety and quality. Therefore, Physician will report the occurrence of and waive all charges related to those conditions specified under Section 5001(c) of the Deficit Reduction Act, Section 2702 of the Affordable Care Act and any related or similar federal or state regulation, in accordance with the terms thereof. Physician agrees to use best efforts to provide Company with prior notice of, and in any event will provide notice as soon as reasonably practicable notice of, any actions taken by or against Physician described in this Section 5.2.

5.3 Information and Records.

5.3.1 Maintenance of Information and Records. Physician agrees (a) to maintain Information and Records (as such terms are defined in Section 5.3.2) in a current, detailed, organized and comprehensive manner and in accordance with customary medical practice, Government Sponsor directives, applicable Federal and state laws, and accreditation standards; (b) that all Member medical records and Confidential Information shall be treated as confidential and in accordance with applicable laws; (c) to maintain such Information and Records for the longer of six (6) years after the last date Physician Services were provided to Member, or the period required by applicable law or Government Sponsor directives; and (d) to maintain Information and Records in accordance with the requirements of Exhibit A. This Section 5.3.1 shall survive the termination of this Agreement, regardless of the cause of the termination.

5.3.2 Access to Information and Records. Physician agrees that (a) Company (including Company's authorized designee) and Government Sponsors shall have access to all data and information obtained, created or collected by Physician related to Members and necessary for payment of claims, including without limitation Confidential Information ("Information"); (b) Company (including Company's authorized designee), Government Sponsors and Federal, state, and local governmental authorities and their agents having jurisdiction, upon request, shall have access to all books, records and other papers (including, but not limited to, contracts, medical and financial records and physician incentive plan information) and information relating to this Agreement and to those services rendered by Physician to Members ("Records"); (c) consistent with the consents and authorizations required by Section 2.7 hereof, Company or its agents or designees shall have access to medical records for the purpose of assessing quality of care, conducting medical evaluations and audits, and performing utilization management functions; (d) applicable Federal and state authorities and their agents shall have access to medical records for assessing the quality of care or investigating Member grievances or complaints ; and (e) Members shall have access to their health information as required by 45 C.F.R. § 164.524 and applicable state law, be provided with an accounting of disclosures of information when and as required by 45 C.F.R. § 164.528 and applicable state law, and have the opportunity to amend or correct the information as required by 45 C.F.R. § 164.526 and applicable state law. Physician agrees to supply copies of Information and Records within fourteen (14) days of the receipt of a request, where practicable, and in no event later than the date required by Government Sponsor directives and any applicable law or regulatory authority. Subject to the provisions of this section as well as other provisions of this Agreement, Company confirms that, as between Company and Physician, Physician owns Physician's medical records. This Section 5.3.2 shall survive the termination of this Agreement, regardless of the cause of termination.

5.3.3 Government Requirements Regarding Records for Medicare Members. In addition to the requirements of Sections 5.3.1 and 5.3.2, with respect to Medicare Plans, Physician agrees to maintain Information and Records (as those terms are defined in Section 5.3) for the longer of: (i) ten (10) years from the end of the final contract period of any government contract of Company, (ii) the date the U.S. Department of Health and Human Services ("HHS"), the U.S. Comptroller General, or their designees complete an audit, or (iii) the period required by applicable laws, rules or regulations. Physician further agrees that, with respect to Medicare Plans, Company and Federal, state and local government authorities having jurisdiction, or their designees, upon request, shall have access to all Information and Records, and that this right of inspection, evaluation and audit of Information and Records shall continue for the longer of (i) ten (10) years from the end of the final contract period of any government contract of Company, (ii) the date HHS, the U.S. Comptroller General, or their designee complete an audit, or (iii) the period required by applicable laws, rules or regulations. This Section 5.3.3 shall survive the termination of this Agreement, regardless of the cause of termination.

5.4 Quality, Accreditation and Review Activities.
Physician agrees to cooperate with any Company quality activities or review of Company or a Plan conducted by the National Committee for Quality Assurance (NCQA) or a Federal or state agency with authority over Company and/or the Plan, as applicable.

5.5 Proprietary Information.

5.5.1 Rights and Responsibilities. Each Party agrees that the Proprietary Information of the other Party is the exclusive property of such Party and that each Party has no right, title or interest in the same. Each Party agrees to keep the Proprietary Information and this Agreement strictly confidential and agrees not to disclose any Proprietary Information or the contents of this Agreement to any third party without the other Party's consent, except (i) to governmental authorities having jurisdiction, (ii) in the case of Company's disclosure to Members, Government Sponsors, consultants or vendors under contract with Company, and (iii) in the case of Physicians' disclosure to Members for the limited purpose of advising Members of potential treatment options and costs consistent with applicable Federal and state laws. Except as otherwise required under applicable Federal or state law, each Party agrees to not use any Proprietary Information of the other Party, and at the request of the other Party hereto, return any Proprietary Information upon termination of this Agreement for whatever reason. Notwithstanding the foregoing, Physician is encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which the Physician is paid. In addition, Physician may freely communicate with patients about their treatment options, regardless of benefit coverage limitations. This Section 5.5.1 shall survive the termination of this Agreement for one (1) year, regardless of the cause of termination.

6.0 TERM AND TERMINATION

6.1 Term.
This Agreement shall be effective for an initial term ("Initial Term") of one (1) year from the Effective Date, and thereafter shall automatically renew for additional terms of one (1) year each, unless and until terminated in accordance with this Article 6.0.

6.2 Termination without Cause.
This Agreement may be terminated by Company at any time without cause with at least ninety (90) days prior written notice to Physician. This Agreement may be terminated by Physician without cause at any time following the conclusion of the Initial Term with at least ninety (90) days prior written notice to Company.

6.3 Termination for Breach.
This Agreement may be terminated at any time by either Party upon at least thirty (30) days prior written notice of such termination to the other Party upon material default or substantial breach by such Party of one or more of its obligations hereunder, unless such material default or substantial breach is cured within thirty (30) days of the notice of termination; provided, however, if such material default or substantial breach is incapable of being cured within such thirty (30) day period, any termination pursuant to this Section 6.3 will

be ineffective for the period reasonably necessary to cure such breach if the breaching party has taken all steps reasonably capable of being performed within such thirty (30) day period. Notwithstanding the foregoing, the effective date of such termination may be extended pursuant to Section 6.6 herein.

6.4 Immediate Termination or Suspension.
Any of the following events shall result in the immediate termination or suspension of this Agreement by Company, upon notice to Physician, at Company's discretion at any time: (a) the suspension, withdrawal, expiration, revocation or non-renewal of any Federal, state or local license, certificate or other legal credential authorizing Physician to practice medicine; (b) a suspension or revocation of Physician's DEA certification or other right to prescribe controlled substances; (c) Physician's indictment, arrest or conviction of a felony or for any criminal charge related to or in any way impairing Physician's practice of medicine; (d) the loss or material limitation of Physician's insurance under Section 2.6 of this Agreement; (e) a determination by Company that Physician's continued participation in provider networks could result in harm to Members; (f) the exclusion, debarment or suspension of Physician from participation in any governmental sponsored program, including, but not limited to, Government Programs, Medicare or the Medicaid program in any state; (g) the listing of Physician in the HIPDB; (h) change of control of Physician's practice to an entity not acceptable to Company; (i) any false statement or material omission in the participation application and/or confidential information forms and all other requested information, as determined by Company in its sole discretion; (j) any adverse action with respect to Physician's hospital staff privileges; or (k) the withdrawal, expiration or termination of the State Contract. To protect the interests of patients, including Members, Physician will provide immediate notice to Company of any of the aforesaid events described in clauses (a) through (j), including notification of impending bankruptcy.

6.5 Obligations Following Termination.
Following the effective date of any expiration or termination of this Agreement or any Plan, Physician and Company will cooperate as provided in this Section 6.5 and in Exhibit A and D. This Section 6.5 and Exhibit A and D shall survive the termination of this Agreement, regardless of the cause of termination.

6.5.1 Upon Termination. Upon expiration or termination of this Agreement for any reason, other than termination by Company in accordance with Section 6.4 above, Physician agrees to provide Physician Services at Company's discretion to: (a) any Member who is inpatient as of the effective date of termination until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) any Member, upon request of such Member or the applicable Plan Sponsor, for one (1) calendar year. The terms of this Agreement, including the **Services and Compensation Schedule** shall apply to all services under this Section 6.5.1.

6.5.2 Upon Insolvency or Cessation of Operations. If this Agreement terminates as a result of insolvency or cessation of operations of Company, and as to Members of HMOs that become insolvent or cease operations, then in addition to other obligations set forth in this section, Physician shall continue to provide Physician Services to: (a) all Members for the period for which premium has been paid; and (b) Members confined as inpatients on the date of insolvency or other cessation of operations until medically appropriate discharge. This provision shall be construed to be for the benefit of Members. No modification of this provision shall be effective without the prior written approval of the applicable regulatory agencies.

6.5.3 Obligation to Cooperate. Upon notice of expiration or termination of this Agreement or of a Plan, Physician shall cooperate with Company and comply with Policies in the transfer of Members to other providers.

6.5.4 Obligation to Notify Members. Upon notice of termination of this Agreement or of a Plan, Company shall provide reasonable advance notice of the impending termination to Members of Plans currently under the treatment of Physician, or in the event of immediate termination, as soon as practicable after termination.

6.6 Obligations During Dispute Resolution Proceedings.

In the event of any dispute between the Parties in which a Party has provided notice of termination under Section 6.3 and the dispute is required to be resolved or is submitted for resolution under Article 8.0 below, the termination of this Agreement shall be stayed and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

7.0 RELATIONSHIP OF THE PARTIES

7.1 Independent Contractor Status.

The relationship between Company and Physician, as well as their respective employees and agents, is that of independent contractors, and neither shall be considered an agent or representative of the other Party for any purpose, nor shall either hold itself out to be an agent or representative of the other for any purpose. Company and Physician will each be solely liable for its own activities and those of its agents and employees, and neither Company nor Physician will be liable in any way for the activities of the other Party or the other Party's agents or employees arising out of or in connection with: (a) any failure to perform any of the agreements, terms, covenants or conditions of this Agreement; (b) any negligent act or omission or other misconduct; (c) the failure to comply with any applicable laws, rules or regulations; or (d) any accident, injury or damage. Physician acknowledges that all Member care and related decisions are the responsibility of Physician and that Policies do not dictate or control Physician's clinical decisions with respect to the care of Members. Physician agrees to indemnify and hold harmless the Government Sponsor and Company from any and all claims, liabilities and third party causes of action arising out of the Physician's provision of care to Members. Company agrees to indemnify and hold harmless the Physician from any and all claims, liabilities and third party causes of action arising out of the Company's administration of health care services in connection with the Plans. This provision shall survive the expiration or termination of this Agreement, regardless of the reason for termination.

7.2 Use of Name.

Physician consents to the use of Physician's name and other identifying and descriptive material in provider directories and in other materials and marketing literature of Company in all formats, including, but not limited to, electronic media. Physician may use Company's names, logos, trademarks or service marks in marketing materials or otherwise, upon receipt of Company's prior written consent, which shall not be unreasonably withheld.

7.3 Interference with Contractual Relations.

Physician shall not engage in activities that will cause Company to lose existing or potential Members, including but not limited to: (a) advising Company customers, Government Sponsors or other entities currently under contract with Company to cancel, or not renew said contracts; (b) impeding or otherwise interfering with negotiations which Company is conducting for the provision of health benefits or Plans; or (c) using or disclosing to any third party membership lists acquired during the term of this Agreement for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Notwithstanding the foregoing, Company shall not prohibit, or otherwise restrict, Physician from advising or advocating on behalf of a Member who is his or her patient, for the following: (i) the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; (ii) any information the Member needs in order to decide among all relevant treatment options; (iii) the risks, benefits, and consequences of treatment or nontreatment; and (iv) the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. This section shall continue to be in effect for a period of one (1) year after the expiration or termination of this Agreement.

8.0 DISPUTE RESOLUTION

8.1 Member Grievance Dispute Resolution.

Physician agrees to (a) cooperate with and participate in Company's applicable appeal, grievance and external review procedures (including, but not limited to, Medicaid appeals and expedited appeals procedures), (b) provide Company with the information necessary to resolve same, and (c) abide by decisions of the applicable appeals, grievance and review committees. Company will make available to Physician

information concerning the Member appeal, grievance and external review procedures at the time of entering into this Agreement.

8.2 Physician Dispute Resolution.
Company shall provide a mechanism whereby Physician may raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Physician shall exhaust this mechanism prior to instituting any arbitration or other permitted legal proceeding. The Parties agree that any dispute that may arise between the Parties shall not disrupt or interfere with the provision of services to Members. Discussions and negotiations held pursuant to this Section 8.2 shall be treated as inadmissible compromise and settlement negotiations for purposes of applicable rules of evidence.

8.3 Arbitration.
Any controversy or claim arising out of or relating to this Agreement including breach, termination, or validity of this Agreement, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration. The arbitration will be administered by the American Arbitration Association ("AAA") or the Judicial Arbitration and Mediation Services ("JAMS") and conducted by a sole Arbitrator. If a party believes that the arbitrator has committed an error of law or legal reasoning, the party can appeal to a court of competent jurisdiction to correct any such error of law or legal reasoning. Depositions for discovery purposes shall not be permitted. The arbitrator may award only monetary damages in accordance with this Agreement.

8.4 Arbitration Solely Between Parties; No Consolidation or Class Action.
Any arbitration or other proceeding related to a dispute arising under this Agreement shall be conducted solely between them. Neither Party shall request, nor consent to any request, that their dispute be joined or consolidated for any purpose, including without limitation any class action or similar procedural device, with any other proceeding between such Party and any third party.

9.0 MISCELLANEOUS

9.1 Amendments.
This Agreement constitutes the entire understanding of the Parties hereto and no changes, amendments or alterations shall be effective unless signed by both Parties, except as expressly provided herein. Company may amend this Agreement upon thirty (30) days prior written notice, by letter, newsletter, electronic mail or other media (an "Amendment"). Failure by Physician to object in writing to any such Amendment within thirty (30) days following receipt thereof constitutes Physician's acceptance of such Amendment. In the event that Physician reasonably believes that an Amendment is likely to have a material adverse impact upon Physician, Physician agrees to notify Company in writing, specifying the specific bases demonstrating a likely material adverse impact, and the Parties will negotiate in good faith an appropriate revised Amendment, if any, to this Agreement. Notwithstanding the foregoing, at Company's discretion, Company may amend this Agreement to comply with applicable law or regulation, or any order or directive of any governmental agency, without the consent of Physician, and this Agreement shall be deemed to be automatically amended to conform with all laws and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over this Agreement. Physician agrees that noncompliance with any requirements of this Section 9.1 will relieve Company or Government Sponsors and Members from any financial liability for the applicable portion of the Physician Services. Changes to Policies are addressed by Section 5.1 hereto.

9.2 Waiver.
The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, all waivers must be in writing and signed by an authorized officer of the Party to be charged. Physician waives any claims or cause of action for fraud in the inducement or execution related hereto.

9.3 Governing Law.
This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State of Iowa.

9.4 Liability.

Notwithstanding Section 9.3, either Party's liability, if any, for damages to the other Party for any cause whatsoever arising out of or related to this Agreement, and regardless of the form of the action, shall be limited to the damaged Party's actual damages. Neither Party shall be liable for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whatsoever sustained as a result of a breach of this Agreement or any action, inaction, alleged tortious conduct, or delay by the other Party.

9.5 Severability.

Any determination that any provision of this Agreement or any application thereof is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Neither Party shall assert or claim that this Agreement or any provision hereof is void or voidable if such Party performs under this Agreement without prompt and timely written objection.

9.6 Successors; Assignment.

This Agreement relates solely to the provision of Physician Services by Physician and does not apply to any other organization which succeeds to Physician assets, by merger, acquisition or otherwise, or is an affiliate of Physician. Neither Party may assign its rights or its duties and obligations under this Agreement without the prior written consent of the other Party, which consent may not be unreasonably withheld; provided, however, that Company may assign its rights or its duties and obligations to an Affiliate or successor in interest so long as any such assignment or delegation will not have a material impact upon the rights, duties and obligations of Physician.

9.7 Headings.

The headings contained in this Agreement are included for purposes of convenience only, and shall not affect in any way the meaning or interpretation of any of the terms or provisions of this Agreement.

9.8 Notices.

Except for any notice required under Article 6, Term and Termination, or if otherwise specified, notices required pursuant to the terms and provisions hereof may be effective if sent by letter, electronic mail or other generally accepted media. With respect to notices required under Article 6, notice shall be effective only if given in writing and sent by overnight delivery service with proof of receipt, or by certified mail return receipt requested. Notices shall be sent to the addresses set forth on the signature page of this Agreement (which addresses may be changed by giving notice in conformity with this Section 9.8). Physician shall notify Company of any changes in the information provided by Physician related to Physician's address.

9.9 Remedies.

Notwithstanding Sections 8.3 and 9.4, the Parties agree that each has the right to seek any and all remedies at law or equity in the event of breach or threatened breach of Section(s) 5.5, 6.6 and 7.3.

9.10 Force Majeure.

If either Party shall be delayed or interrupted in the performance or completion of its obligations hereunder by any act, neglect or default of the other Party, or by an embargo, war, act of terror, riot, incendiary, fire, flood, earthquake, epidemic or other calamity, act of God or of the public enemy, governmental act (including, but not restricted to, any government priority, preference, requisition, allocation, interference, restraint or seizure, or the necessity of complying with any governmental order, directive, ruling or request) then the time of completion specified herein shall be extended for a period equivalent to the time lost as a result thereof. This Section 9.10 shall not apply to either Party's obligations to pay any amounts owing to the other Party, nor to any strike or labor dispute involving such Party or the other Party.

9.11 Non-Exclusivity.

This Agreement is not exclusive, and nothing herein shall preclude either Party from contracting with any other person or entity for any purpose. Company makes no representation or guarantee as to the number of Members who may select or be assigned to Physician.

9.12 Confidentiality**.**
It is further understood and agreed by and among the Parties that the terms and conditions of this Agreement, except as otherwise specified, are and shall remain confidential, and shall not be disclosed by either Party without express written consent of the other Party or as required by law or by governmental authorities or by express order by a court having jurisdiction over the Party from whom disclosure is sought.

9.13 Entire Agreement.
This Agreement (including any attached schedules and/or addendum) constitutes the complete and sole contract between the Parties regarding the subject matter described above and supersedes any and all prior or contemporaneous oral or written representations, communications, proposals or agreements not expressly included in this Agreement and may not be contradicted or varied by evidence of prior, contemporaneous or subsequent oral representations, communications, proposals, agreements, prior course of dealings or discussions of the Parties. The Parties understand and agree that this Agreement only applies to the Plans described in this Agreement and, likewise, this Agreement does not and will not supersede any agreement(s) between Company's affiliates and Provider that relates to Company's affiliates other lines of business that are not the subject of this Agreement (that are not the Plans described in this Agreement).

9.14 Signatures. Facsimile and electronic signatures shall be deemed to be original signatures for all purposes of this Agreement.

9.15 Incorporation of Recitals. The Parties incorporate the recitals into this Agreement as representations of fact to each other.

Remainder of page intentionally left blank. Signature page follows.

IN WITNESS WHEREOF, the undersigned parties have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.

PHYSICIAN	**COMPANY**
By:_____	By:_____
Printed Name:_____	Printed Name:_____
Title:_____	Title:_____
Date:_____	Date:_____

REIMBURSEMENT ADDRESS:

_____
_____
_____

MAIN TELEPHONE NUMBER:_____

CHIEF EXECUTIVE OFFICER:_____

CHIEF FINANCIAL OFFICER:_____

BUSINESS OFFICE MANAGER:_____

FEDERAL TAX I.D. NUMBER:_____

NPI NUMBER:_____

As required by Section 9.8 ("Notices") of this Agreement, notices shall be sent to each Party at the following addresses:

To Physician at:
_____
_____
_____
_____

To Company at:

Aetna Better Health of Iowa
ATTN: Network Management
4320 NW 114th Street
Urbandale, IA 50322

With a copy to:
Aetna
Law Dept, Medicaid, Mail Code RE6A
151 Farmington Avenue
Hartford, CT 06156-0001

PROGRAM PARTICIPATION SCHEDULE

Physician agrees to participate in the Plans and other health benefit programs listed herein:

Iowa Medicaid managed care Plans offered by Aetna Better Health of Iowa Inc., pursuant to contract with the Iowa Department of Human Services for delivery of high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa hawk-i programs.

SERVICES AND COMPENSATION SCHEDULE

1.0 COMPENSATION

Iowa Medicaid and CHIP Plans: Aetna Medicaid Market Fee Schedule

2.0 SERVICES

Provider will be reimbursed for those Covered Services in accordance with the terms of this Agreement that are within the scope of and appropriate to the Provider's license and certification to practice.

3.0 GENERAL COMPENSATION TERMS AND CONDITIONS

Definitions

"Aetna Medicaid Market Fee Schedule (AMMFS)" – A fee schedule that is based upon the contracted location where service is performed and the State of Iowa Medicaid Fee Schedule.

"Medicare Allowable" - the current payment as of discharge date that a hospital will receive from Company, subject to the then current Medicare Inpatient Prospective Payments Systems and will be updated in accordance with CMS changes, provided, however, that exempt units for psychiatric, rehabilitation and skilled nursing facility services will be paid in accordance with the applicable Medicare Prospective Payment Systems. These payments are intended to mirror the payment a Medicare Fiscal Intermediary ("FI") would make to the hospital, less (with respect to DRG-based payments) the payments for Indirect Medical Education (IME), Direct Graduate Medical Education (DGME), bad debt, as appropriate and adjusted by CMS or Government Sponsor for sequestration, SGR or other items and Aetna payment and processing guidelines. For other provider types, the Medicare allowable rate is based upon CMS Geographic Pricing Cost Indices (GPCI) and Resource Based Relative Value Scale (RBRVS) Relative Value Units (RVU) including Outpatient Prospective Payment System (OPPS) cap rates; the Clinical Laboratory Fee Schedule (CLAB); the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule; including PEN (DMEPOS) and 'Medicare Part B Drug Average Sales Price (ASP),' as appropriate. Coding and fees determined under this schedule will be updated as CMS releases code updates, changes in the MFS relative values, including OPPS cap payments, or the CMS conversion factors. Company plans to update the schedule within 90 days of the final rates and/or codes being published by CMS. However, the rates and coding sets for these services do not become effective until updates are completed by Company and payment is considered final and exclusive of any retroactive or retrospective CMS adjustments to the rate. Company payment policies apply to services paid based upon the Medicare allowable rate.

General

A. Member Cost Share. Rates are inclusive of any applicable Member Copayment, Coinsurance or Deductible.

B. Billing. When billing, Provider must designate applicable codes related to those Covered Services provided by Provider under the terms of this Agreement.

C. Coding. Company utilizes nationally recognized coding structures including, but not limited to, Revenue Codes as described by the Uniform Billing Code, AMA Current Procedural Terminology (CPT4), CMS Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), ICD-9 Diagnosis and Procedure codes, and National Drug Codes (NDC). As changes are made to nationally-recognized codes, Company will update internal systems to accommodate new codes. Such changes will only be made when there is no material change in the procedure itself. Until updates are complete, the procedure will be paid according to the standards and coding set for the prior period.

The use of ICD-10 coding shall not impact the aggregate rates and compensation intended by the Parties as set forth in this Services and Compensation Schedule. Consequently, in the event that use of ICD-10 codes result in aggregate payments that would differ from the aggregate payments that would have resulted based on ICD-9 coding (excluding utilization and validated case mix severity changes), the rates set forth in this Services and Compensation Schedule will be reviewed by Company periodically and adjusted at least annually in order to reflect what would have been paid had ICD-9 coding been utilized for determination of the payments.

Company will comply and utilize nationally recognized coding structures as directed under applicable Federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act (HIPAA).

Exhibit A

Iowa Regulatory Compliance Addendum

This Regulatory Compliance Addendum is incorporated by reference into the Agreement. It applies to Iowa Medicaid managed care plans offered by Better Health of Iowa Inc. ("Company"), pursuant to contract with the Iowa Department of Human Services (DHS) for delivery of high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa hawk-i programs and the eligible populations covered by the State Contract between Company and DHS. This Addendum is effective as of the Effective Date of the Agreement.

Provider agrees that all applicable terms and conditions set out in the RFP, the State Contract, any incorporated documents and all applicable state and federal laws, as amended, govern the duties and responsibilities of the Provider with regard to the provision of services to members in the programs applicable hereto. The RFP and State Contract may currently be found at: http://bidopportunities.iowa.gov/?pgname=viewrfp&rfp_id=11140

If there is any conflict between the terms of this Addendum and any of the other terms of the Agreement, including any attachments, schedules, exhibits and/or addenda made part of the Agreement, the terms of this Addendum will govern and control; provided, however, if there is any conflict between any of the terms of the Agreement, including this Addendum, and the State Contract, then the terms of the State Contract will govern and control. For purposes of this Regulatory Compliance Addendum, the term "Provider" shall mean the health care physician, provider, group, facility or hospital executing the Agreement, as identified on the first page of the Agreement.

1.0 DEFINITIONS [taken from the RFP Glossary]

When used in this Agreement, all capitalized terms shall have the following meanings:

Children's Health Insurance Program ("CHIP"). The program created in 1997 by Title XXI of the Social Security Act and known in Iowa as CHIP.

Claim. A formal request for payment for benefits received or services rendered.

CMS. The Centers for Medicare and Medicaid Services.

Co-Payment. A cost-sharing arrangement in which a Member pays a specified charge for a specified service; also called a co-pay.

Covered Services. Those health care services/benefits to which an individual eligible for Medicaid/CHIP is entitled under the Iowa Medicaid State Plan and which Company is required to provide or arrange for pursuant to the State Contract.

IDPH. Iowa Department of Public Health.

IDPH Participants. A resident of the State of Iowa with an income at or below 200% of the federal poverty guidelines as published by the Department of Health and Human Services who is not insured or for whom third party payment is not available to pay for services. An Iowa Medicaid member shall not be an IDPH Participant. An Iowa Health and Wellness Plan member may be an IDPH Participant for those IDPH-funded substance use disorder services that are not fully covered by the Iowa Health and Wellness Plan.

Iowa Department of Human Services ("DHS"). The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Iowa.

Iowa Medicaid State Plan. The binding written agreement between DHS and CMS, which describes how the Medicaid program is administered and determines the services for which DHS will receive federal financial participation.

Medicaid. A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act Amendment. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving covered individuals.

Medical Records. All medical, behavioral health, and long-term care histories; records, reports and summaries; diagnoses; prognoses; record of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, behavioral health, and long-term care documentation in written or electronic format; and analyses of such information.

Medically Necessary Services. Those Covered Services that are, under the terms and conditions of the State Contract, determined through Company utilization management to be:

(1) Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the Member;

(2) Provided for the diagnosis or direct care and treatment of the condition of the Member enabling the Member to make reasonable progress in treatment;

(3) Within standards of professional practice and given at the appropriate time and in the appropriate setting;

(4) Not primarily for the convenience of the Member, the Member's physician or other provider; and

(5) The most appropriate level of Covered Services, which can safely be provided.

Member. A Medicaid recipient who is subject to mandatory enrollment or is currently enrolled in Company's coverage under the State Contract.

Policies. In addition to the policies and procedures promulgated by Company, which relate to the duties and obligations of the Parties under the terms of the Agreement, Policies include the general principles by which DHS is guided in its management of the Title XIX program, as further set forth and defined by DHS promulgations and by state and federal rules and regulations.

Provider Preventable Conditions. Situations in which Medicaid payment is prohibited for services that should have been avoidable as defined in 42 CFR §447.26.

State Contract. The written agreement between Company and DHS, a copy of which may be found by Provider on the State's website. The State Contract is comprised of and incorporates all provisions of the RFP and any addenda, appendices, attachments or amendments thereto, as well as any Member handbook, provider handbook and/or other applicable policy guides, manuals and materials.

2.0 PROVIDER SERVICES AND OBLIGATIONS

2.1 Medical Necessity.
Provider agrees that for the purposes of Covered Services to Members, "Medically Necessary Services" shall be as defined above in this Addendum.

2.2 Timely Access.
Provider must meet the standards for timely access to care and services for Members as set forth on Exhibit B to the RFP, taking into account the urgency of the need for services. Provider must offer hours of operation to Members that are no less than the hours of operation offered to other non-Medicaid patients, or if Provider serves only Medicaid beneficiaries, hours of operation comparable to the hours of operation offered to enrollees of any Iowa Medicaid Fee for Service Program. Provider agrees to provide Covered Services to Members on a twenty-four (24) hour per day, seven (7) day per week basis. [42 CFR 438.209]

2.3 Inability To Pay Co-Payment.

Provider shall not deny care or services to any Member because of the Member's inability to pay the Co-Payment. [RFP SOW §5.3.5]

2.4 Medical Records.

Provider shall create and maintain Medical Records for Members in accordance with applicable law including, but not limited to, Iowa Administrative Code Title 441, Chapter 79.3 and Policies. Without limiting the foregoing, Provider's records must be maintained in a manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical Records must be legible, signed, dated and maintained as required by law. Provider shall provide a copy of the Member's Medical Record to the Member upon reasonable request by the Member at no charge. Provider shall facilitate the transfer of a Member's Medical Record to another provider at the Member's request. Provider must maintain the confidentiality of and access to Medical Records in accordance with the standards mandated in the Health Insurance Portability and Accountability Act and all other state and federal requirements. Provider shall permit Company, representatives of DHS, and other authorized entities to review Members' Medical Records for purpose of monitoring Provider's compliance with the record standards, capturing information for clinical studies, monitoring quality or any other reason. Without limiting the foregoing, Provider will release mental health information regarding Members only as allowed by Iowa Code §228. [RFP SOW §6.1.9 & 2.15]

2.5 Member Rights.

Provider shall take Members' rights as set forth in law into account when providing services to Members. Such rights include the right to receive information as set forth in 42 CFR §438.100, the right to be treated with respect and with due consideration for his or her dignity and privacy; the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand; the right to participate in decisions regarding his or her health care, including the right to refuse treatment; the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion; the right to treatment in the least restrictive setting; the right to fully participate in the community and to work, live and learn to the fullest extent possible; and the right to be furnished health care services in accordance with 42 CFR §§438.206 through 438.210. [RFP SOW §1.4.1]

2.6 Critical Incidents.

If Provider is a provider who has personal contact with Members under the Home-and-Community-Based Services (HCBS) habilitation and waiver services, Provider shall (i) report critical incidents; (ii) respond to critical incidents; (iii) document critical incidents; and (iv) cooperate with any investigation conducted by Company or an outside agency. Provider shall complete any critical incident training required by Company. [RFP SOW §10.4.2]

2.7 Enforcement of §6032 of the 2005 Deficit Reduction Act (DRA).

If Provider receives five million dollars ($5,000,000) or more in Medicaid payments in a federal fiscal year, Provider shall have written policies for all employees, including management, and for all employees of any contractor or agent, that provide detailed information about the following: [RFP SOW §12.12]

a. The Federal False Claims Act under title 31 of the United States Code, sections 3729 through 3733;

b. Administrative remedies for false claims and statements under title 31 of the United States Code, chapter 38;

c. Any State laws pertaining to civil or criminal penalties for false claims and statements (Iowa Code 249A.8 and 714.8(10)-714.14);

d. Whistleblower protections under such laws; and

e. The Provider's policies and procedures for detecting and preventing fraud, waste, and abuse.

2.8 Additional Duties For Nursing Facilities. If Provider is a nursing facility, Provider shall: [RFP SOW §6.1.2.1]

a. Promptly notify Company of a Member's admission or request for admission to the nursing facility as soon as the facility has knowledge of such admission or equest for admission;

b. Notify the Company immediately if the nursing facility is considering discharging a Member and to consult with the Member's care coordinator;

c. Notify the Member and/or the Member's representative (if applicable) in writing prior to discharge in accordance with state and federal requirements;

d. Collect from any Member the Member's patient liability amount as communicated to Provider by Company. Provider agrees that payments from Company to Provider will be net of the applicable patient liability amount for any Member with patient liability.

e. Notify Company of any change in a Member's medical or functional condition that could impact the Member's level of care eligibility for the currently authorized level of nursing facility services;

f. Comply with federal Preadmission Screening and Resident Review ("PASRR") requirements to provide or arrange to provide specialized services and all applicable Iowa law governing admission, transfer and discharge policies; and

g. hereby agrees that the Agreement will automatically be terminated in accordance with federal requirements if Provider is involuntarily decertified by the State or CMS.

2.9 Additional Duties for Home and Community-Based Services. If Provider provides Home and Community-Based Services, Provider shall: [RFP SOW §6.1.2.2]

a. Provide at least thirty (30) days advance notice to the Company when the Provider is no longer willing or able to provide services to a Member and to cooperate with the Member's care coordinator to facilitate a seamless transition to alternate providers;

b. In the event that a HCBS provider change is initiated for a Member, regardless of any other provision in Agreement, continue to provide services to the Member in accordance with the Member's plan of care until the Member has been transitioned to a new provider, as determined by the Company, or as otherwise directed by the Company, which may exceed thirty (30) days from the date of notice to the Company;

c. Immediately report any deviations from a Member's service schedule to the Member's care coordinator;

d. Comply with the critical incident reporting requirements.

e. Comply with all child and dependent adult abuse reporting requirements.

2.10 Additional Duties for Community-Based Services Providers For Resident Transfer and Discharge. Neither Company nor Provider shall transition nursing facility, ICF/ID, 1915(i) Habilitation or 1915(c) community-based residential alternative residents to another facility or residence unless: (i) the Member or

his/her representative specifically requests to transition; (ii) the Member or his/her representative provides written consent to transition based on quality or other concerns raised by the Company or Provider, which shall not include the residential provider's rate of reimbursement; or (iii) the provider has chosen not to contract with the Company. The Company shall establish contractual terms with its providers, subject to approval by DHS, that protects an individual from involuntary discharge that may lead to a placement in an inappropriate or more restrictive setting. The Company shall facilitate a seamless transition whenever a Member transitions between facilities or residences. [RFP SOW §4.3.10]

2.11 Additional Duties for Providers with IDPH Participants.
If Provider provides services to IPDH Participants who are intravenous ("IV") drug users, Provider shall perform outreach activities. Provider shall select, train and supervise outreach workers. Provider shall encourage individuals needing IV treatment to undergo treatment and provide awareness about the relationship between IV drug use and communicable disease. Provider shall use outreach models that are applicable to the local situation and use an approach that can be expected to be reasonably effective. [RFP SOW §3.2.8.15]

2.12 Additional Duties for IHH Providers.
If Provider provides integrated health homes services, Provider agrees to provide the following: (i) quality-driven, cost-effective, culturally appropriate, and person-and family-driven health home services; (ii) high-quality health care services informed by evidence-based clinical practice guidelines; (iii) preventive and health promotion services informed by evidence-based clinical practice guidelines; (iv) preventive and health promotion services, including prevention of mental illness and substance use disorders; (v) comprehensive care management, care coordination and transitional care across settings; (vi) chronic disease management, including self-management support to Members and their families; (vii) demonstrating a capacity to use health information technology to link services, facilitate communication among team members and between the health home team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and (viii) establishing a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level. [RFP SOW §3.2.9.1.2]

3.0 CLAIMS SUBMISSION, COMPENSATION AND MEMBER BILLING

3.1 Timely Filing.
Provider shall submit all Claims that do not involve a third party payer, to Company within ninety (90) days of the date of service. [RFP SOW §6.1.2]

3.2 Cost Sharing and Patient Liability.
Provider shall not require any cost sharing or patient liability responsibilities for Covered Services except to the extent that cost sharing or patient liabilities are required for those services in accordance with law and the Agreement. [RFP SOW §3.2.15.3]

3.3 Third Party Liability.
Provider shall identify any third party liability coverage available to a Member, including Medicare and long-term care insurance, as applicable, and except as otherwise required, seek such third party liability payment before submitting Claims to Company. [RFP SOW §6.1.2]

3.4 Payment Net of Co-Payment.
Provider acknowledges and agrees that Company shall reduce the amount of payment it makes to Provider by the amount of the Member's Co-Payment obligation regardless of whether Provider has collected or waived the Co-Payment, except as provided in 42 C.F.R. §447.56(c). [RFP SOW §5.3.6]

3.5 Missed Appointments.
Provider shall not charge Members for missed appointments. [RFP SOW §3.2.15.3]

3.6 IDPH Participant Substance Use Disorder Services.

If and to the extent Provider provides substance use disorder services to IDPH Participants, Provider agrees to accept payment from the IDPH Participant according to the IDPH-approved siding fee schedule for such substance use disorder services. Providers billing and collection procedures for IDPH Participants shall be consistent with those established and provided by the IDPH. Provider agrees that services funded partially or completely by IDPH shall not be denied to a person because of the inability of the person or group to pay a fee for the service. Further, Provider shall not charge and IDPH Participant for missed appointments; provided, however, that Provider may charge the IDPH Participant a one-time no-show fee in an amount not to exceed that established by the IDPH. Provider acknowledges and agrees that IDPH funds are the payment of last resort for substance use disorder services provided to IDPH Participants and shall comply with IDPH and Company policies on IDPH eligibility for person with insurance coverage. [RFP SOW §5.5 & 13.6.4]

3.7 Provider Preventable Conditions.

Provider acknowledges and agrees that Company shall not make payment to Provider for a Provider Preventable Condition. This includes health-acquired conditions as identified by Medicare other than deep vein thrombosis and pulmonary embolism following total knee replacement or hip replacement surgery in pediatric and obstetric patients. Company shall also not make payment for wrong surgical or other invasive procedure on a patient or surgical, other invasive procedure performed on the wrong body part or wrong patient or any future additional to the list of non-reimbursable Provider Preventable Conditions. As a condition of payment under the Agreement, Provider agrees to comply with the reporting requirements for Provider Preventable Conditions found at 42 CFR §447.26(d). [RFP SOW §10.5]

4.0 GENERAL PROVISIONS

4.1 Debarred Individuals.

Provider represents and warrants that Provider is not and at no time has been (i) a person debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or (ii) an affiliate, as defined in the Federal Acquisition Regulation, of a person described in subsection (i) above. Provider shall immediately notify Company if at any time this representation and warranty is no longer accurate. [RFP SOW §2.6]

Exhibit D

Medicare Compliance Addendum

Without limiting any obligation of Provider under the Agreement, Provider agrees to the requirements set forth in this Addendum. Capitalized terms not otherwise defined herein, including within Schedule 1 attached hereto, shall have the meanings ascribed to them in the Agreement.

1. DESCRIPTION. This Addendum includes any Medicare plan(s) offered by Company to Medicare beneficiaries under a contract with the Centers for Medicare and Medicaid Services pursuant to Part C of Title XVIII of the Social Security Act ("Medicare Plans"). The Medicare Plans included in this Addendum do NOT include any Medicare Advantage plan(s) that the Company has deemed to be Medicare High Performance Network plans. From time to time Company and/or Payers may designate only certain Participating Providers to take part in the provider delivery network for a particular Product benefit plan(s).

2. PAYMENT.

A. In consideration of Provider's agreement to perform Covered Services in accordance with the Agreement, Provider shall be paid for Covered Services performed according to the terms of the applicable Service and Rate Schedule.

B. Company shall not pay any amounts beyond the amounts set forth in the applicable Service & Rate Schedule, including but not limited to any incentive payments that may be payable under traditional Medicare, except as expressly required by the Agreement or applicable law. Further, the Parties acknowledge and agree that payments under the Medicare program to providers, suppliers, and Medicare Advantage organizations may be adjusted as the result of legislation, regulation, executive order or other federal mandate ("Medicare Payment Adjustment"). Furthermore, any such Medicare Payment Adjustment could result in an increase or decrease in Medicare payments. In accordance with the terms of this Agreement, the Parties agree that, in the event of a Medicare Payment Adjustment, Company's payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. Company shall adjust payments under this Agreement for Covered Services rendered by Provider on and after the effective date of the Medicare Payment Adjustment, and shall continue to adjustment payments to Provider for until the earlier of (i) the Medicare Payment Adjustment is discontinued or (ii) is replaced by a subsequent Medicare Payment Adjustment.

C. Pursuant to Section 6.K. of this Addendum, Provider certifies that the diagnosis codes submitted to Company for Medicare Members that Company is required to submit to CMS will be accurate, complete and truthful ("Certification"). Provider acknowledges and agrees that Company may impose a penalty on Provider not to exceed five thousand dollars ($5,000) for each instance that Provider submits a diagnosis code to Company for a Medicare Member that does not comply with this Certification because the diagnosis code was not submitted in the format described in 42 C.F.R. § 422.310 or any subsequent or additional federal regulations. For purposes of this Section 2, "diagnosis code" shall mean an International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) code or its successor.

D. Federal laws and regulations limit the timeframe within which CMS may recover overpayments made to physicians, providers, and suppliers who submit claims to Medicare contractors (such as fiscal intermediaries, regional home health intermediaries, carriers, Medicare Administrative Contractors, and Durable Medical Equipment Medicare Administrative Contractors) for services provided or supplied to Medicare beneficiaries enrolled in Original Medicare ("Medicare Statute of Limitations"). If Company makes an overpayment or payment in error to Provider for Medicare Members, Company shall have the right to initiate overpayment recovery efforts within the same timeframe available to CMS under the Medicare Statute of Limitations; provided that no time limit shall apply to initiation of overpayment recovery efforts based on Company's reasonable suspicion of fraud or other intentional misconduct.

3. ASSIGNMENT. In addition to all other rights of Company under the Agreement, the Agreement (including, but not limited to, as it relates to the line(s) of business described in this Addendum) may be assigned by Company, at any time and from time to time, in whole or in part, to any other affiliate or successor in interest. At Company's option, the Agreement shall survive, without any other change in its terms, as a distinct, separate agreement with

Company for those products/lines of business designated by Company and in duplicate form as a separate, distinct participating provider agreement with the applicable affiliate(s)/successor(s) for the products/lines of business assigned to such entity(ies). In the event of any assignment under this paragraph, Company shall provide advance written notice to Provider. In the event of a conflict between this paragraph and any other provision of the Agreement, the terms of this paragraph shall supersede and prevail.

4. EFFECT OF TERMINATION. In the event this Addendum is terminated for any reason, such termination shall not constitute termination of any of Company's other products, plans or programs.

5. MEDICARE REQUIRED PROVISIONS. Provider agrees to comply with all of the provisions of Schedule 1, attached hereto and incorporated into this Addendum.

6. PROVIDER OBLIGATIONS.
A. Provision of Covered Services. Provider agrees to provide to Medicare Members the health care services for which Provider is licensed and customarily provides in accordance with accepted medical and surgical standards in the community. Provider shall make Covered Services available and accessible to Medicare Members, including telephone access to Provider, on a twenty-four (24) hours, seven (7) days per week basis.

B. Provider agrees that all Medicare Services and other activities performed by Provider under the Agreement will be consistent and comply with Company's obligations as a Medicare Advantage Organization under Company's contracts with CMS. Upon request, Provider shall immediately provide to Company any information that is required by Company to meet its reporting obligations to CMS, including without limitation, physician incentive plan information, if applicable. To the extent that Provider generates and/or compiles and provides any data to Company that Company, in turn, submits to CMS, Provider certifies, to the best of its knowledge and belief, that such data is accurate, complete and truthful. Provider agrees to cooperate with and participate in internal and external review procedures necessary to allow Company to process Medicare appeals and grievances in accordance with Medicare laws, regulations and CMS instructions.

C. Federal Fund Obligations. Provider understands and agrees that payments received by Company for the Medicare Plans from CMS pursuant to the Medicare Plan's contract with CMS are Federal funds. As a result, Provider, by entering into this Agreement and the terms of this Addendum, is subject to laws applicable to individuals/entities receiving Federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R. part 84, the Age Discrimination Act of 1975 as implemented by regulations at 45 C.F.R. part 91, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

D. Continuation of Services. In the event Company's Medicare contract for the Medicare Plans with CMS terminates or Company becomes insolvent, Provider shall continue to provide Covered Services to Medicare Members who are hospitalized through the later of: (a) the date for which premiums were paid, or (b) through the date of discharge. Provider is prohibited by law from billing Medicare Members for such Covered Services. This provision shall survive the termination of this Agreement or Addendum, regardless of the reason for termination, including the insolvency of Company, and shall supersede any oral or written agreement between Provider and a Medicare Member.

E. Policies, Programs & Procedures. Provider agrees to comply with Company's policies and procedures (which Company shall provide to Provider upon request) which operationalize many of the requirements of the Agreement, this Addendum, and the Medicare Program. Provider agrees to comply with Company's quality improvement, administrative processes and procedures, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures, and any other policies Company may implement, including amendments made to the above mentioned policies, procedures and programs from time to time. In the event that a Company policy or procedure conflicts with a provision in the Agreement, then the language in the Agreement (including all amendments, exhibits, and attachments thereto) shall govern.

F. Maintenance of Records. Provider shall preserve records applicable to Medicare Members or to Company's participation in the Medicare Program, for the longer of: (i) the period of time required by State and Federal law, or (ii) ten (10) years, whichever is longer. In addition, to the extent applicable to Provider, Provider, on behalf of itself and any Downstream Entities with whom Provider has contracted, agrees to comply with 42 C.F.R. §422.2480(c)

and to maintain all records containing data used by Company to calculate Medicare medical loss ratios ("MLRs") for Company's Medicare Products and/or evidence needed by Company and/or federal governmental authorities with jurisdiction to validate MLRs (collectively, "MLR Records") for a minimum of ten (10) years from the date such MLRs were reported by Company to CMS.

G. Subcontractors. Provider shall require all of its subcontractors, if any, to comply with all applicable Medicare laws, regulations and CMS instructions.

(1) Provider shall include in Provider's contracts with subcontractors all of the contractual and legal obligations required by Company or the laws, regulations, rules and directions of CMS, including, without limitation, that any delegated services or activities to be performed by subcontractor shall be consistent and comply with the obligations in the contract between CMS and Company governing Company's participation in the Medicare Program. To the extent CMS requires additional provisions to be included in such subcontracts, Provider shall amend its contracts accordingly.

(2) Provider shall ensure that any vendors, subcontractors or other such entities that have a need to know the terms of the Agreement also maintain the privacy and confidentiality of all financial terms of the Agreement.

(3) If Provider arranges for the provision of Covered Services from other health care providers for Medicare Members, such contracts shall be in writing and shall specify the delegated activities and reporting responsibilities, in addition to meeting the requirements described above. In the event that Company delegates to Provider the selection of providers, Company retains the right to approve, suspend or terminate such delegation. If Company delegates the selection of providers, Company will either review the credentials of medical professionals affiliated with Provider or Company will review, approve, and audit on an ongoing basis Provider's credentialing process. The term "Subcontractor" as used in this Section shall not refer to employees or other individuals that perform services on behalf of Provider for which Provider bills such services under this Agreement. Provider represents and warrants that such persons are subject to all terms and conditions of this Agreement and Provider shall provide written evidence of such as described in the Agreement.

H. Contracts with Excluded Entities. Provider understands and agrees that no person that provides health care services under this Agreement, or persons that provide utilization review, medical social work or administrative services in support of services billed under this Agreement by Provider may be an individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. Provider hereby certifies that no such excluded person will provide such services under this Agreement and no such excluded persons will be employed by or utilized by any Downstream Entity with which Provider contracts relating to the furnishing of these services to Medicare Members. In accordance with applicable laws, rules and regulations and the Compliance Program Guidelines, Provider agrees to review the Department of Health and Human Services ("HHS") Office of Inspector General List of Excluded Individuals and Entities and the General Service Administrative Excluded Parties Lists System (collectively, "Exclusion Lists") to ensure that Provider Related Parties are not included on such Exclusion Lists. Provider agrees to review the Exclusion Lists prior to initially hiring, appointing or contracting with any new Provider Related Party and at least once per month thereafter to confirm that Provider Related Parties are not included on such Exclusion Lists. Provider agrees that if a Provider Related Party appears on an Exclusion List and/or is excluded from participation in any federally-funded health program, Provider will immediately remove the Provider Related Party from any work related directly or indirectly to Company's Medicare Plans, and take all corrective actions required under applicable laws, rules or regulations. In the event Provider or any Provider Related Parties are listed in an Exclusion List after the Effective Date of this Addendum, Company shall have the right, in its sole discretion and judgment, to terminate this Addendum in accordance with the Agreement or to disqualify the listed person(s) from providing any part of the Covered Services. For the purpose of this section "Provider Related Parties" means Provider's permanent and temporary employees and Downstream Entities that are involved in the performance of Medicare Services.

I. Offshore Services. Provider is prohibited from using any individual or entity ("Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative or other individual or entity) to perform any services for Medicare Plans if the individual or entity is physically located outside of one of the fifty

United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands) ("Offshore Services"), unless Company, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity. Provider further agrees that Company has the right to audit any Offshore Entity prior to the provision of Offshore Services for Medicare Plans. Additionally, Provider acknowledges and agrees that Offshore Services that involve Medicare Member protected health information (PHI) are subject to CMS reporting within thirty (30) days of: (1) performing, or contracting with an Offshore Entity to perform, Offshore Services, and (2) any time Provider changes the Offshore Services that an Offshore Entity will perform.

J. Submission of Encounter Data. Provider hereby acknowledges that Company is required to provide CMS and other federal and state regulatory agencies and accrediting organizations with encounter data as requested by such agencies and organizations. Such data may include medical records and all other data necessary to characterize each encounter between Provider and a Medicare Member. Provider agrees to cooperate with Company and to provide Company with all such information in such form and manner as requested by Company. Provider agrees to immediately notify Company if any encounter data that Provider submitted to Company for Medicare Members is inaccurate, incomplete or erroneous, and cooperate with Company to correct erroneous encounter data to ensure Company's compliance with Medicare laws, rules and regulations and CMS instructions.

K. Certification of Data. Provider recognizes that as a Medicare Advantage organization, Company is required to certify the accuracy, completeness and truthfulness of data that CMS requests. Such data include encounter data, payment data, and any other information provided to Company by its contractors and subcontractors. Provider and its subcontractors, if any, hereby certify that any such data submitted to Company will be accurate, complete and truthful. Upon request, Provider shall make such certification in the form and manner prescribed by Company.

L. Medicare Member Complaints. Provider agrees to cooperate with Company in resolving any Medicare Member complaints related to coverage for the provision of Covered Services. Company will notify Provider as necessary concerning all Medicare Member complaints involving Provider. Provider shall, in accordance with the Provider's regular procedures, investigate such complaints and respond to Company in the required time. Provider shall use best efforts to resolve complaints in a fair and equitable manner.

M. Compliance Program and Anti-Fraud Initiatives. Provider shall (and shall cause its subcontractors to) institute, operate, and maintain an effective compliance program to detect, correct and prevent the incidence of non-compliance with CMS requirements and the incidence of fraud, waste and abuse (FWA) relating to the operation of Company's Medicare Program. Such compliance program shall be appropriate to Provider's or subcontractor's organization and operations and shall include: (a) written policies, procedures and standards of conduct articulating the entity's commitment to comply with federal and state laws, as well as providing mechanisms for employee/subcontractor use in adhering to the expectation that Provider and employee/subcontractor report potential non-compliance or FWA issues (internally and to Company, as applicable); (b) for all officers, directors, employees, contractors and agents of Provider or subcontractor, required participation in effective compliance and anti-fraud training and education that is consistent with guidance that CMS has or may issue with respect to compliance and anti-fraud and abuse initiatives, unless exempt from such training under relevant CMS regulations. This includes general compliance and FWA training completion, as well as code of conduct dissemination, initially within ninety (90) days of hire/contracting and at least annually thereafter; Provider and subcontractors, as applicable, may use Company's code and training or an equivalent; and (c) processes to oversee subcontractors to ensure their compliance with these requirements.

N. Marketing. Consistent with Federal laws, regulations, and agency requirements applicable to the Medicare Advantage Program, Provider shall not: (1) engage in any marketing or sales activities that could mislead or confuse Medicare beneficiaries, or (2) market or advertise non-health care related products to Medicare Members or prospective Medicare Members. Further, Provider shall at all times comply with the then current Medicare Marketing Guidelines.

O. Dual-Eligible Hold Harmless. Provider acknowledges and agrees that Medicare Members who are also enrolled in a State Medicaid plan ("Dual Eligible Members") are not responsible for paying to Provider any Copayments, Coinsurance or Deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when the State Medicaid plan is responsible for paying such Cost Sharing Amounts. Provider further agrees that they will

not collect Cost Sharing Amounts from Dual Eligible Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the Company's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts, or bill the applicable State Medicaid plan for the appropriate Cost Sharing Amounts owed by the State Medicaid plan.

7. COMPANY OBLIGATIONS.
A. Fee Schedule. Company shall arrange for Provider to be compensated for health care services rendered to Medicare Members in accordance with Section 2 of this Addendum.

B. Prompt Pay. In accordance with 42 C.F.R. § 422.520(a)(1), Company shall make best efforts to pay clean claims submitted by Provider for Covered Services provided to Medicare Members within thirty (30) calendar days of receipt. For purposes of this Addendum, the term "clean claim" shall have the meaning assigned in 42 C.F.R. §422.500.

8. GENERAL PROVISIONS
A. Termination. This Addendum may be terminated on its own without respect to the remainder of the Agreement with or without cause by either Party in accordance with the termination provisions of the underlying Agreement. This Addendum shall terminate automatically in the event that the underlying Agreement is terminated in accordance with the termination provisions of the Agreement.

B. Governing Law. This Addendum shall be governed by Federal laws, regulations, and agency requirements applicable to the Medicare Advantage Program. In the event that changes to the governing laws, regulations, or agency requirements applicable to the Medicare Advantage Program occur, the new law, regulation or agency requirement shall supersede to the extent required by any such later required changes.

C. All other terms and provisions of the Agreement not amended hereby shall remain in full force and effect, without modification. In the event of any inconsistency between the terms of this Addendum and the Agreement, the terms of this Addendum shall govern and control.

D. Survival. All provisions of this Addendum which by their nature should survive termination of Provider's provision of Medicare Services under this Agreement or termination of the Agreement as a whole, shall survive termination.

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Schedule 1

Medicare Required Provisions

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement between Company and Provider (referred to in this Schedule 1 as "FDR") not inconsistent herein shall remain in full force and effect. This Exhibit shall supersede and replace any inconsistent provisions to such Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

NOW, THEREFORE, the parties agree as follows:

A. Definitions:

1. Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

2. Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

3. Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

4. Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

5. First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

6. Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

7. Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

8. Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

9. Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

10. Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes

services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

B. <u>Required Provisions</u>:

FDR agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with Company's Affiliates included in this Agreement, (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)] and [42 CFR §423.505]

2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph 1 of this amendment directly from any first tier, downstream, or related entity. For records subject to review under paragraph 1, except in exceptional circumstances, CMS will provide notification to the MA organization that a direct request for information has been initiated. [42 C.F.R. §§ 422.504(i)(2)(ii) and (iii)]

3. FDR will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118] and [42 CFR §423.136]

4. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)] and [42 CFR §423.505(i)(3)(i)]

5. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. FDR may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

6. Any services or other activity performed in accordance with a contract or written agreement by FDR are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)] and [42 CFR §423.505(i)(3)(iii)]

7. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between the MA Organization/Physician and the provider. [42 C.F.R. §§ 422.520(b)(1) and (2)]
   See Section 7.b of the Addendum to which this Schedule 1 is attached.

8. FDR and any related entity, contractor or subcontractor will comply with all applicable Federal and Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)] and [42 CFR §423.505(i)(4)(iv)]

9. If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity:

[INFORMATIONAL NOTE: If there is no delegation of a specific activity or responsibility, please delete the related provision and replace with "None delegated".]

(i) The delegated activities and reporting responsibilities are specified as follows:

[List activities and reporting responsibilities or enter the section and name of the delegation or applicable agreement].

(ii) CMS and the MA organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.

(iii) The MA organization will monitor the performance of the parties on an ongoing basis.

[Enter any applicable section and name of the delegation or applicable agreement].

(iv) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.

[**Enter any applicable section and name of the delegation or applicable agreement].**

(v) If the MA organization delegates the selection of providers, contractors, or subcontractor, the MA organization retains the right to approve, suspend, or terminate any such arrangement.

[42 C.F.R. §§ 422.504(i)(4) and (5)]

In the event of a conflict between the terms and conditions above and the terms of a related agreement, the terms above control.

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Aetna Better Health of Iowa
Hospital Services Agreement

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Aetna Better Health of Iowa

Hospital Services Agreement Checklist

_____ **All** pages of this document must be printed and returned to Aetna Better Health (not just the signature pages).

_____ **Page 1**. The Hospital name that is filled in on the top of page one must match **exactly** with the name on the W9. Leave the effective date blank. This will be filled in by Aetna Better Health.

_____ **Signature Page.** The signature page must be signed by an authorized hospital representative. In addition, all information listed below the signature line (TIN, NPI, and Reimbursement Address, etc.) must be completed.

_____ **Hospital Application**. The Aetna Better Health Hospital Application must be completed and returned with the signed contract.

_____ **W9**. A W9 form must be returned with the contract. As indicated above, the name on the W9 must match exactly the name listed on pages 1 and the signature page of the Agreement.

Please return all documents to:

Aetna Better Health of Iowa
Attn: Network Management
4320 NW 114th Street
Urbandale, IA 50322

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AETNA BETTER HEALTH OF IOWA
HOSPITAL SERVICES AGREEMENT

The term of this Medicaid Hospital Services Agreement (the "Agreement") by and between Aetna Better Health of Iowa Inc., an Iowa corporation on behalf of itself and its Affiliates (hereinafter "Company"), and _____ (hereinafter "Hospital"), shall commence effective _____, 20___ [Date to be completed by Company] (the "Effective Date"). The Regulatory Compliance Addendum (Exhibit A) and Medicare Compliance Addendum (Exhibit D, including Schedule 1) attached to this Agreement, are expressly incorporated into this Agreement and are binding upon the Parties. In the event of any inconsistent or contrary language between the Addenda and any other part of this Agreement, including but not limited to exhibits, attachments or amendments, the Parties agree that the provisions of the Addenda shall prevail.

WHEREAS, Company administers Plans for Government Sponsors that provide access to health care services to Members or arranges for the provision of health care services to Members of Government Programs; and

WHEREAS, Company contracts with certain health care providers and facilities to provide access to such health care services to Members; and

WHEREAS, Hospital provides health care services to patients within the scope of its licensure or accreditation; and

WHEREAS, Company and Hospital mutually desire to enter into an arrangement whereby Hospital will become a Participating Provider and render health care services to Members; and

WHEREAS, in return for the provision of health care services by Hospital, Company will pay Hospital for Covered Services under the terms of this Agreement; and

WHEREAS, Hospital understands and agrees that Government Sponsors or other government entities may require certain changes to the terms of this Agreement before Hospital can provide services to Members under the terms of any Plans that are awarded, by the Government Sponsors, to Company.

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants, promises and undertakings herein, the sufficiency of which is hereby acknowledged, and intending to be legally bound hereby, the parties agree as follows:

1.0 DEFINITIONS

When used in this Agreement, all capitalized terms shall have the following meanings:

Affiliate. Any corporation, partnership or other legal entity (including any Plan) directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company.

Clean Claim. A claim that can be processed without obtaining additional information from the Hospital who provided the service or from a third party, except that it shall not mean a claim submitted by or on behalf of a Hospital who is under investigation for fraud or abuse, or a claim that is under review for medical necessity; provided, further, unless otherwise required by law or regulation, a claim which (a) is submitted within the proper timeframe as set forth in this Agreement and (b) has (i) detailed and descriptive medical and patient data, (ii) a corresponding referral (whether in paper or electronic format), if required for the applicable claim, (iii) whether submitted via an electronic transaction using permitted standard code sets (e.g., CPT-4, IDC-9 (or successor standard), HCPCS) as required by the applicable Federal or state regulatory authority (e.g., U.S. Dept. of Health & Human Services, U.S. Dept. of Labor, state law or regulation) or otherwise, all the data elements of the UB-04 or CMS-1500 (or successor standard) forms (including but not limited to Member identification number, national provider identifier ("NPI"), date(s) of service, complete and accurate breakdown of services), and (c) does not involve coordination of benefits, and (d) has no defect or error (including any new procedures with no CPT code, experimental procedures or other circumstances not contemplated at the time of execution of this Agreement) that prevents timely adjudication.

Coinsurance. A payment a Member is required to make under a Plan which is determined as a percentage of the lesser of: (a) the rates established under this Agreement; or (b) Hospital's usual, customary and reasonable billed charges.

Confidential Information. Any information that identifies a Member and is related to the Member's participation in a Plan, the Member's physical or mental health or condition, the provision of health care to the Member or payment for the provision of health care to the Member. Confidential Information includes, without limitation, "individually identifiable health information," as defined in 45 C.F.R. § 160.103 and "non-public personal information" as defined in laws or regulations promulgated under the Gramm-Leach-Bliley Act of 1999.

Copayment. A charge required under a Plan that must be paid by a Member at the time of the provision of Covered Services, or at such other time as determined by Hospital and which is expressed as a specific dollar amount.

Covered Services. Those health care services for which a Member is entitled to receive coverage under the terms and conditions of a Plan. The Parties agree that Company is obligated to pay for only those Covered Services that are determined to be medically necessary, as determined in accordance with the Member's applicable Plan.

Deductible. An amount that a Member must pay for Covered Services during a specified coverage period in accordance with the Member's Plan before benefits will be paid.

Effective Date. Defined in first paragraph of this Agreement.

Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, her pregnancy or health or the health of her fetus) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part; or such other definition as may be required by applicable law.

Emergency Services. Covered Services furnished by a qualified provider and necessary to evaluate or stabilize an Emergency Medical Condition.

Government Programs. Plans operated and/or administered by Company pursuant to a State Contract.

Government Sponsor. A state agency or other governmental entity authorized to offer, issue and/or administer one or more Plans, and which, to the extent applicable, has contracted with Company to administer all or a portion of such Plan(s).

Hospital. Defined in first paragraph of this Agreement.

Hospital-Based Physicians. Any physician employed by Hospital, or who otherwise provides those services to Members as listed in the Services and Compensation Schedule attached hereto and made a part hereof.

Hospital Services. Defined in Section 2.1 of this Agreement.

Material Change. Any change in Policies that could reasonably be expected, in Company's determination, to have a material adverse impact on (i) Hospital's reimbursement for Hospital Services or (ii) Hospital administration.

Medically Necessary or Medical Necessity. Health care services that a physician or other applicable health care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or

treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendation and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member. An individual covered by or enrolled in a Plan.

Participating Provider. Any physician, hospital, hospital-based physician, skilled nursing facility, mental health and/or substance abuse professional (which shall include psychiatrists, psychologists, social workers, psychiatric nurses, counselors, family or other therapists or other mental health/substance abuse professionals), or other individual or entity involved in the delivery of health care or ancillary services who or which has entered into and continues to have a current valid contract with Company to provide Covered Services to Members, and, where applicable, has been credentialed by Company or its designee consistent with the credentialing policies of Company or its designee, as applicable. Certain categories of Participating Providers may be referred to herein more specifically as, e.g., "Participating Physicians" or "Participating Hospitals."

Party. Company or Hospital, as applicable. Company and Hospital may be referred to collectively as the "Parties."

Plan. A Member's health care benefits as set forth in the State Contract. Such Plans are listed in the **Program Participation Schedule** attached hereto and made a part hereof.

Policies. The policies and procedures promulgated by Company which relate to the duties and obligations of the Parties under the terms of this Agreement, including, but not limited to: (a) quality improvement/management; (b) utilization management, including, but not limited to, precertification of elective admissions and procedures, concurrent review of services and referral processes or protocols; (c) pre-admission testing guidelines; (d) claims payment review; (e) member grievances; (f) provider credentialing; (g) electronic submission of claims and other data required by Company; and (h) any applicable participation criteria required by the State in connection with the Government Programs. Policies also include those policies and procedures set forth in the Company's and/or Government Sponsor's manuals (as modified from time to time) as Company determines appropriate in its sole discretion; clinical policy bulletins made available via Company's internet web site; and other policies and procedures, whether made available via a password-protected web site for Participating Providers (when available), by letter, newsletter, electronic mail or other media.

Post-Stabilization Care Services. Covered Services relating to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, under circumstances defined in federal regulations, to improve or resolve the Member's condition.

Proprietary Information. Any and all information, whether prepared by a Party, its advisors or otherwise, relating to such Party or the development, execution or performance of this Agreement whether furnished prior to or after the Effective Date. Proprietary Information includes but is not limited to, with respect to Company, the development of a pricing structure, (whether written or oral) all financial information, rate schedules and financial terms which relate to Hospital and which are furnished or disclosed to Hospital by Company. Notwithstanding the foregoing, the following shall not constitute Proprietary Information:

(a) information which was known to a receiving Party (a "Recipient") prior to receipt from the other Party (a "Disclosing Party") (as evidenced by the written records of a Recipient);

(b) information which was previously available to the public prior to a Recipient's receipt thereof from a Disclosing Party;

(c) information which subsequently became available to the public through no fault or omission on the part of a Recipient, including without limitation, the Recipient's officers, directors, trustees, employees, agents, contractors and other representatives;

(d) information which is furnished to a Recipient by a third party which a Recipient confirms, after due

inquiry, has no confidentiality obligation, directly or indirectly, to a Disclosing Party; or

(e) information which is approved in writing in advance for disclosure or other use by a Disclosing Party.

Specialty Program. A program for a targeted group of Members with certain types of illnesses, conditions, cost or risk factors.

Specialty Program Providers. Those hospitals, physicians and other providers that have been identified or designated by Company or the Government Sponsor to provide Covered Services associated with a Specialty Program.

State Contract. Company's contract(s) with Government Sponsors to administer Plans or Government Programs identified in the **Program Participation Schedule**, including the member handbook, provider handbook and other applicable manuals and materials.

2.0 HOSPITAL SERVICES AND OBLIGATIONS

2.1 Provision of Services.

Hospital will make available and provide to Members Covered Services, including facilities, equipment, personnel or other resources necessary to provide such Covered Services according to generally accepted standards of hospital practice ("Hospital Services"). Upon written notice from Hospital, Company may agree to add new or relocating facilities and locations to existing Agreement upon completion of applicable credentialing and satisfaction of all other requirements of Company. Other demographic information may be revised upon written notice from Hospital.

2.2 Non-Discrimination and Equitable Treatment of Members.

Hospital agrees to provide Hospital Services to Members with the same degree of care and skill as customarily provided to Hospitals' patients who are not Members, according to generally accepted standards of practice. Hospital and Company agree that Members and non-Members should be treated equitably. Hospital agrees not to discriminate against Members on the basis of race, ethnicity, gender, creed, ancestry, lawful occupation, age, religion, marital status, sexual orientation, mental or physical disability, medical history, color, national origin, place of residence, health status, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment for services, cost or extent of Hospital Services required, or any other grounds prohibited by law or this Agreement and will abide by Company's cultural competency Policies. Hospital shall deliver Covered Services in a culturally competent manner to Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds, and comply with Company's Policies on cultural competency.

2.3 Federal Law.

Company is a Federal contractor and an Equal Opportunity Employer which maintains an Affirmative Action Program. To the extent applicable to Hospital, Hospital, on behalf of itself and any subcontractors, agrees to comply with the following, as amended from time to time: Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq., and regulations promulgated thereunder, Executive Order 11246, the Vietnam Era Veterans Readjustment Act of 1974, the Drug Free Workplace Act of 1988, Section 503 of the Rehabilitation Act of 1973, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") administrative simplification rules at 45 CFR parts 160, 162, and 164, the Americans with Disabilities Act of 1990, Federal laws, rules and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (Section 1128B(b) of the Social Security Act), and any similar laws, regulations or other legal mandates applicable to recipients of federal funds and/or transactions under or otherwise subject to any government contract of Company.

2.4 Hospital Representations.

2.4.1 General Representations. Hospital represents, warrants and covenants, as applicable, that: (a) it is, and will remain throughout the term of this Agreement, accredited by The Joint Commission or the Bureau of Hospitals of the American Osteopathic Association; (b) it is, and will remain throughout the term of this Agreement, in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided hereunder, including, without limitation, statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, false claims and prohibition of kickbacks; (c) it is certified to participate in the Medicaid and Medicare programs; with such accreditation or participation applicable to all Hospital Services; (d) all Hospital-Based Physicians are properly credentialed, privileged, and re-appointed within the scope of their specialty; (e) all ancillary health care personnel employed by, associated or contracted with Hospital who treat Members ("Ancillary Personnel"): (i) are and will remain throughout the term of this Agreement appropriately licensed and/or certified (when and as required by state law) and supervised, and qualified by education, training and experience to perform their professional duties; and (ii) will act within the scope of their licensure or certification, as the case may be; (f) Hospital's credentialing, privileging, and re-appointment procedures are in accordance with its medical staffs by-laws, regulations, and policies, comply with The Joint Commission standards, meet the querying and reporting requirements of the National Practitioner Data Bank ("NPDB") and Healthcare Integrity and Protection Data Bank ("HIPDB"), and fulfill all applicable state and Federal standards; (g) this Agreement has been executed by its duly authorized representative; and (h) executing this Agreement and performing its obligations hereunder shall not cause Hospital to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

2.4.2 Government Program Representations. Company has or shall seek contracts to serve beneficiaries of Government Programs. To the extent Company participates in such Government Programs, Hospital agrees, on behalf of itself and any subcontractors of Hospital acting on behalf of Hospital, to be bound by all rules and regulations of, and all requirements applicable to, such Government Programs. Hospital acknowledges and agrees that all provisions of this Agreement shall apply equally to any employees, independent contractors and subcontractors of Hospital who provide or may provide Covered Services to Members of Government Programs, and Hospital represents and warrants that Hospital shall cause such employees, independent contractors and subcontractors to comply with this Agreement, the State Contract, and all applicable laws, rules and regulations and perform all requirements applicable to Government Programs. Any such subcontract or delegation shall be subject to prior written approval by Company. With respect to Members of Government Programs, Hospital acknowledges that compensation under this Agreement for such Members constitutes receipt of Federal funds. Hospital agrees that all services and other activities performed by Hospital under this Agreement will be consistent and comply with the obligations of Company and/or Government Sponsor under its contract(s) with the Centers for Medicare and Medicaid Services ("CMS"), and any applicable state regulatory agency, to offer Government Program. Hospital further agrees to allow Government Sponsor, CMS, any applicable state regulatory agency, and Company to monitor Hospital's performance under this Agreement on an ongoing basis in accordance with Medicare/Medicaid laws, rules and regulations. Hospital acknowledges and agrees that Company may only delegate its activities and responsibilities under the State Contract or any Company contract(s) with Government Sponsor, CMS and any applicable regulatory agency, to offer Government Program in a manner consistent with applicable laws, rules and regulations, and that if any such activity or responsibility is delegated by Company to Hospital, the activity or responsibility may be revoked if Government Sponsor, CMS or Company determine that Hospital has not performed satisfactorily. Upon request, Hospital shall immediately provide to Company any information that is required by Company to meet its reporting obligations to CMS, including without limitation, physician incentive plan information, if applicable. To the extent that Hospital generates and/or compiles and provides any data to Company that Company, in turn, submits to CMS, Hospital certifies, to the best of its knowledge and belief, that such data is accurate, complete and truthful.

2.4.3 Government Program Requirements. Hospital, on behalf of itself and each Hospital-Based Physician, hereby agrees to perform its obligations under this Agreement in accordance with the terms and conditions set forth in Exhibits A and D.

2.4.4 Qualified Providers. Hospital shall exclude any physician or other provider from performing services in connection with this agreement if such provider has been suspended or terminated from participation in Government Programs or any other government-sponsored program, including Medicare or the Medicaid program in any state. Hospital is prohibited from using any individual or entity ("Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative or other individual or entity) to perform any services for Plans if the individual or entity is physically located outside of one of the fifty United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands.), unless Company, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity. Hospital further agrees that Company has the right to audit any Offshore Entity prior to the provision of services for Plans.

2.4.5 Suspension or Debarment. Hospital represents, warrants and covenants, as applicable, that it and each Hospital-Based Physician:

a. Has not within a three year period preceding the proposal submission been convicted or had a civil judgment rendered against him/her/it for commission of fraud or criminal offense in performing a public transaction or contract (local, state or federal) or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property; and

b. Is not presently indicted for or otherwise criminally or civilly charged by a governmental entity with the commission of any of the above offenses; and

c. Has not within a five year period preceding execution of this Agreement had one or more public transactions terminated for cause or fault; and

d. Is not excluded, debarred or suspended from participation in any government-sponsored program including, but not limited to, Government Programs, Medicare or the Medicaid program in any state; and

e. Will immediately report any change in the above status to Company; and

f. Will maintain all appropriate licenses to perform its duties and obligations under the Agreement.

2.5 Hospital's Insurance.
During the term of this Agreement, Hospital agrees to procure and maintain such policies of general and professional liabilityand other insurance, or a comparable program of self-insurance, at minimum levels as required by state law or, in the absence of a state law specifying a minimum limit, an amount customarily maintained by Hospital in the state or region in which the Hospital operates. Such insurance coverage shall cover the acts and omissions of Hospital as well as those Hospital's agents and employees. Hospital agrees to deliver certificates of insurance or other documentation as appropriate to show evidence of such coverage to Company upon request. Hospital agrees to make best efforts to provide to Company at least thirty (30) days advance notice, and in any event will provide notice as soon as reasonably practicable, of any cancellation or material modification of said policies.

2.6 Product Participation.
Hospital agrees to participate in the Plans and other health benefit programs listed on the **Program Participation Schedule**. Company reserves the right to introduce and designate Hospital's participation in new Plans, Specialty Programs and other programs during the term of this Agreement and will provide Hospital with written notice of such new Plans, Specialty Programs and other programs and the associated

compensation. To the extent that Company establishes and/or participates in a provider Pay-for-Performance incentive program or Performance Improvement Programs, Hospital agrees to comply with and participate in such program.

Nothing herein shall require that Company identify, designate or include Hospital as a preferred participant in any specific Plan for which Company provides incentives based upon the use of selected Participating Hospitals, Specialty Program or other program; provided, however, Hospital shall accept compensation in accordance with this Agreement for the provision of any Covered Services to Members under a Plan, Specialty Program or other program in which Hospital has agreed to participate hereunder.

2.7 Consents to Release Medical Information.
Hospital covenants that it will obtain from Members to whom Hospital Services are provided, any necessary consents or authorizations to the release of Information and Records to Company, Government Sponsors, their agents and representatives in accordance with any applicable Federal or state law or regulation or this Agreement.

3.0 COMPANY OBLIGATIONS

3.1 Company's Covenants.
Company or Government Sponsors shall provide Members with a means to identify themselves to Hospital (e.g., identification cards), explanation of provider payments, a general description of products, a listing of Participating Providers, and timely notification of material changes in this information. Company shall provide Hospital with a means to check eligibility. Company shall include Hospital in the Participating Provider directory or directories for the Plans, Specialty Programs and products in which Hospital is a Participating Provider, including when Hospital is designated as preferred participant, and shall make said directories available to Members. Company reserves the right to determine the content of provider directories.

3.2 Company Representations.
Company represents and warrants that: (a) this Agreement has been executed by its duly authorized representative; and (b) executing this Agreement and performing its obligations hereunder shall not cause Company to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

The parties acknowledge that one or more state governmental authorities may recommend or require that various Company agreements, including this Agreement, be executed prior to the issuance to Company of one or more approvals, consents, licenses, permissions or other authorizations from governmental authorities with jurisdiction over the subject matter of this Agreement, or which Company deems to be necessary or desirable in its sole discretion (collectively, a "License"). Hospital agrees that all Company obligations to perform, and all rights of Hospital, under this Agreement are expressly conditioned upon the receipt of all Licenses. Failure of Company to obtain any License shall impose no liability on Company under this Agreement.

3.3 Company's Insurance.
Company at its sole cost and expense agrees to procure and maintain such policies of general and/or professional liability and other insurance (or maintain a self-insurance program) as shall be necessary to insure Company and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any service by Company under this Agreement and the administration of Plans.

4.0 CLAIMS SUBMISSIONS, COMPENSATION AND MEMBER BILLING

4.1 Claim Submission and Payment.

4.1.1 Hospital Obligation to Submit Claims. Hospital agrees to submit Clean Claims to Company for Hospital Services rendered to Members. Hospital agrees to submit claim and encounter data related to

a Member enrolled in a Government Program in the form and manner as specified by Company, and, Hospital certifies that any such data is accurate, complete and truthful. Hospital represents that, where necessary, it has obtained signed assignments of benefits authorizing payment for Hospital Services to be made directly to Hospital. Hospital will make best commercial efforts to submit a minimum of eighty-five percent (85%) of its Member claims electronically to Company. For claims Hospital submits electronically, Hospital shall not submit a claim to Company in paper form unless Company requests paper submissions or fails to pay or otherwise respond to electronic claims submission in accordance with the time frames required under this Agreement or applicable law or regulation. Hospital agrees that Company, or the applicable Government Sponsor, will not be obligated to make payments for billings received more than one hundred and twenty (120) days (or such other period required by applicable state law or regulation)from (a) the date of service or, (b) when Company is the secondary payer, from the date of receipt of the primary payer's explanation of benefits. Company may waive this requirement if Hospital provides notice to Company, along with appropriate evidence, of other extraordinary circumstances outside the control of Hospital that resulted in the delayed submission. In addition, unless Hospital notifies Company of its payment disputes within one hundred eighty (180) days, or such other time as required by applicable state law or regulation, of receipt of payment from Company, such payment will be considered full and final payment for the related claims. If Hospital does not timely bill Company or Government Sponsors, or dispute any payment, timely as provided in this Section 4.1.1, Hospital's claim for payment will be deemed waived and Hospital will not seek payment from Government Sponsors, Company or Members. Hospital shall pay on a timely basis all Participating Providers, employees, independent contractors and subcontractors who render Covered Services to Members of Company's Plans for which Hospital is financially responsible pursuant to this Agreement.

Hospital agrees to permit claim editing to the primary procedure those services considered part of, incidental to, or inclusive of the primary procedure and make other adjustments for inappropriate billing or coding (e.g., rebundling, duplicative procedures or claim submissions, mutually exclusive procedures, gender/procedure mismatches, age/procedure mismatches). To the extent Hospital is billing on a CMS 1500, as of the Effective Date, in performing adjustments for inappropriate billing or coding, Company utilizes a commercial software package (as modified by Company for all Participating Providers in the ordinary course of Company's business) which commercial software package relies upon Government Programs and other industry standards in the development of its rebundling logic.

In circumstances where the compensation under this Agreement is intended to include the services of Hospital-Based Physicians, Hospital shall be financially responsible for payment to all Hospital-Based Physicians who render Covered Services to Members and such Hospital-Based Physicians shall look solely to Hospital for payment. Notwithstanding, Company reserves the right to pay any Hospital-Based Physician for Covered Services for which Hospital is financially responsible and for which a valid, undisputed invoice, or portion thereof, is outstanding for more than fourteen (14) days beyond its due date, except that Company need not wait fourteen (14) days if Hospital has engaged in a pattern of late payments in the past. If Hospital cannot resolve the claims submitted by the Hospital–Based Physicians, Company has the right to recoup other amounts owed in order to recover from Hospital any money that Company has paid to the Hospital-Based Physicians.

Subject to applicable law: (i) Company may update internal payment systems in response to additions, deletions, and changes to Government Sponsor, CMS, or other industry source codes without obtaining any consent from Hospital or any other party, and Company will provide, at the written request of Hospital, a copy of the fee schedule in effect at the time of such request; (ii) Company shall not be responsible for communicating such routine changes of this nature, and will update any applicable payment schedules on a prospective basis within ninety (90) days from the date of publication or such longer period as Company determines appropriate in its sole discretion; and (iii) Company shall have no obligation to retroactively adjust claims.

4.1.2 Company Obligation to Pay for Covered Services.. Company shall make payments to Hospital for Covered Services on a timely basis consistent with the claims payment procedure described at 42

U.S.C. § 1396a(a)(37)(A). Company agrees to pay Hospital for non-capitated Covered Services rendered to Members according to the lesser of (i) Hospital's actual billed charges or (ii) the rates set forth in the **Services and Compensation Schedule**, attached hereto and made a part hereof. Company must pay ninety percent (90%) of all such Clean Claims from Hospital within thirty (30) days following actual receipt; provided, further, Company must pay ninety-nine percent (99%) of all Clean Claims from Hospital within ninety (90) days following actual receipt.. Hospital will make best commercial efforts to utilize online explanation of benefits or electronic remittance of advice (or combination thereof) and electronic funds transfer in lieu of receiving paper equivalents to the extent such services are available from Company. Company reserves the right to recoup any overpayment or payment made in error (e.g., a duplicate payment or payment for services rendered by Hospital to a patient who was not a Member and amounts identified through routine investigative reviews of records or audits) against any other monies due to Hospital under this Agreement.

In the event that Hospital identifies any overpayments by Company, Hospital shall, as required under Section 6402(a) of the Patient Protection and Affordable Care Act, report and return any and all such overpayments to Company within sixty (60) days of Hospital's identification of any and all such overpayments. In addition, when reporting and returning any such overpayments by Company, Hospital must provide Company with a written reason for the overpayment (e.g., excess payment under coordination of benefits, etc.).

To the extent, if any, that the compensation under certain Plans is in the form of capitation payments or a case-based rate methodology, Hospital acknowledges the financial risks to Hospital of this arrangement and has made an independent analysis of the adequacy of this arrangement. Hospital, therefore, agrees and covenants not to bring any action asserting the inadequacy of these arrangements or that Hospital was in any way improperly induced by Company to accept the rate of payment, including, but not limited to, causes of actions for damages, rescission or termination alleging fraud or negligent misrepresentation or improper inducement.

Complaints or disputes concerning payments for the provision of services as described in this Agreement shall be subject to the Company's grievance resolution system.

4.1.3 Eligibility Determinations. Company shall have the right to recover payments made to Hospital if the payments are for services provided to an individual who is later determined to have been ineligible based upon information that is not available to Company at the time the service is rendered or authorization is provided

4.1.4 Utilization Management. The Parties agree that Company, on its behalf and on behalf of Government Sponsors, reserves the right to perform utilization management (including retrospective review) and to adjust or deny payment for the inefficient delivery of Hospital Services related to admissions, or length of stay. To facilitate timely and accurate concurrent utilization management, Hospital and Company will cooperate as necessary to facilitate on-site and/or concurrent telephonic utilization management at Hospital. Company agrees that it will not conduct retrospective review so long as Company has been provided a reasonable opportunity to conduct full and complete concurrent utilization management review in accordance with Policies while the Member was hospitalized, except where (1) Hospital, a Participating Provider or any other provider rendering care at or on behalf of Hospital, has provided inaccurate or incomplete information to Company or (2) the patient was not a known Member as of the time of the provision of care.

4.2 Coordination of Benefits.

Except as otherwise required under applicable Federal, state law or regulation or a Plan, when Company or a Government Sponsor is secondary payer under applicable coordination of benefit principles, and payment from the primary payer is less than the compensation payable under this Agreement without coordination of benefits, then Company or Government Sponsor will pay Hospital the lesser of (i) the copayment, coinsurance and deductible amount for the Covered Services as reported on the explanation of benefits of the primary payer, or (ii) the amount of the difference between the amount paid by the primary payer and the compensation payable under this Agreement, absent other sources of payment. Notwithstanding any other

provision of this paragraph, if payment from the primary payer is greater than or equal to the compensation payable under this Agreement without coordination of benefits, neither Company, Government Sponsor nor the applicable Member (in accordance with Section 4.3.2 below) shall have any obligation to Hospital. Notwithstanding anything to the contrary in this section, in no event shall Hospital collect more than Medicare allows if Medicare is the primary payer. Medicaid is never the primary payer.

4.3 Member Billing.

4.3.1 Permitted Billing of Members. Hospital may bill or charge Members only in the following circumstances: (a) applicable Copayments, Coinsurance and/or Deductibles, if any, not collected at the time that Covered Services are rendered; and (b) for services that are not Covered Services only if: (i) the Member's Plan provides and/or Company confirms that the specific services are not covered; (ii) the Member was advised in writing prior to the services being rendered that the specific services may not be Covered Services; and (iii) the Member agreed in writing to pay for such services after being so advised. Hospital acknowledges that Company's denial or adjustment of payment to Hospital based on Company's performance of utilization management as described in Section 4.1.3 or otherwise is not a denial of Covered Services under this Agreement or under the terms of a Plan, except if Company confirms otherwise under this Section 4.3. Hospital may bill or charge individuals who were not Members at the time that services were rendered.

4.3.2 Holding Members Harmless. Hospital hereby agrees that in no event, including, but not limited to the failure, denial or reduction of payment by Company, insolvency of Company or breach of this Agreement, shall Hospital bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse (i) against Members or persons acting on their behalf (other than Company) or (ii) any settlement fund or other *res* controlled by or on behalf of, or for the benefit of, a Member for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance, Deductibles made in accordance with the terms of the applicable Plan. Hospital further agrees that this Section 4.3.2: (a) shall survive the expiration or termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) supersedes any oral or written contrary agreement or waiver now existing or hereafter entered into between Hospital and Members or persons acting on their behalf.

4.3.3 Cost Sharing Protections for Dual Eligible Members. Hospital acknowledges and agrees that Medicare Members who are also enrolled in a State Medicaid plan ("Dual Eligible Members") are not responsible for paying to Hospital any Copayments, Coinsurance or Deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when the State Medicaid plan is responsible for paying such Cost Sharing Amounts. Hospital further agrees that they will not collect Cost Sharing Amounts from Dual Eligible Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the Company's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts, or bill the applicable State Medicaid plan for the appropriate Cost Sharing Amounts owed by the State Medicaid plan. Dual Eligible Members in Capitated Financial Alignment Demonstration Plans are not responsible for Cost Sharing Amounts for Medicare Parts A and B services.

To protect Members, Hospital agrees not to seek or accept or rely upon waivers of the Member protections provided by this Section 4.3.

5.0 COMPLIANCE WITH POLICIES

5.1 Policies.

Hospital agrees to accept and comply with Policies of which Hospital knows or reasonably should have known (e.g., Clinical Policy Bulletins or other Policies made available to Participating Providers). Except when a Member requires Emergency Services, Hospital agrees to comply with any applicable precertification and/or referral requirements under the Member's Plan prior to the provision of Hospital Services. Hospital will utilize the electronic real time HIPAA compliant transactions, including but not limited to, eligibility, precertification and claim status inquiry transactions to the extent such electronic real time features are

utilized by Company. Hospital agrees to notify Company of all admissions of Members, and of all services for which Company requires notice, upon admission or prior to the provision of such services. For the purpose of pre-admission testing, Hospital agrees to directly provide testing or accept test results and examinations performed outside Hospital provided such tests and examinations are: (a) performed by a state licensed laboratory for laboratory tests, and a licensed physician for such other tests and examinations; and (b) performed within a time reasonably proximate to the admission. For those Members who require services under a Specialty Program, Hospital agrees to work with Company in transferring the Member's care to a Specialty Program Provider, as the case may be. Company may at any time modify Policies. Company will provide notice by letter, newsletter, electronic mail or other media, of Material Changes. Failure by Hospital to object in writing to any Material Change within thirty (30) days following receipt thereof constitutes Hospital's acceptance of such Material Change. In the event that Hospital reasonably believes that a Material Change is likely to have a material adverse financial impact upon Hospital, Hospital agrees to notify Company in writing, specifying the specific bases demonstrating a likely material adverse financial impact, and the Parties will negotiate in good faith an appropriate amendment, if any, to this Agreement. Notwithstanding the foregoing, at Company's discretion, Company may modify the Policies to comply with applicable law or regulation, or any order or directive of any governmental agency, without the consent of Hospital, and the Policies shall be deemed to be automatically amended to conform with all laws and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over this Agreement. Hospital agrees that noncompliance with any requirements of this Section 5.1 or any Policies will relieve Company or Government Sponsors and Members from any financial liability for the applicable portion of the Hospital Services.

5.2 Notices and Reporting.

To the extent neither prohibited by law nor violative of applicable privilege, Hospital agrees to provide notice to Company, and shall provide all information reasonably requested by Company regarding the nature, circumstances, and disposition, of: (a) any action taken by Hospital adversely affecting medical staff membership of Participating Physicians and other Participating Providers, whether or not such actions are reportable to NPDB or HIPDB; (b) any litigation or administrative action brought against Hospital or any of its employees, medical staff members or affiliated providers which is related to the provision of health care services and could have a material impact on the Hospital Services provided to Members; (c) any investigation initiated by The Joint Commission or any government agency or program against or involving Hospital or any of its employees, medical staff members or affiliated providers that does or could adversely affect Hospital's The Joint Commission accreditation status, licensure, or certification to participate in the Medicare or Medicaid programs; (d) any change in the ownership or management of Hospital; and (e) any material change in services provided by Hospital or licensure status related to such services, including without limitation a significant decrease in medical staff or the closure of a service unit or material decrease in beds or emergency services departments. Company and Hospital agree to be mutually committed to promoting Member safety and quality. Therefore, Hospital will report the occurrence of and waive all charges related to those conditions specified under Section 5001(c) of the Deficit Reduction Act, Section 2702 of the Affordable Care Act and any related or similar federal or state regulation, in accordance with the terms thereof. Hospital agrees to use best efforts to provide Company with prior notice of, and in any event will provide notice as soon as reasonably practicable notice of, any actions taken by Hospital described in this Section 5.2.

5.3 Information and Records.

5.3.1 Maintenance of Information and Records. Hospital agrees (a) to maintain Information and Records (as such terms are defined in Section 5.3.2) in a current, detailed, organized and comprehensive manner and in accordance with customary medical practice, Government Sponsor directives, applicable Federal and state laws, and accreditation standards; (b) that all Member medical records and Confidential Information shall be treated as confidential and in accordance with applicable laws; (c) to maintain such Information and Records for the longer of six (6) years after the last date Hospital Services were provided to Member, or the period required by applicable law or Government Sponsor directives; and (d) to maintain Information and Records in accordance with the requirements of Exhibits A and D, as applicable. This Section 5.3.1 shall survive the termination of this Agreement, regardless of the cause of the termination.

5.3.2 Access to Information and Records. Hospital agrees that (a) Company (including Company's authorized designee) and Government Sponsors shall have access to all data and information obtained, created or collected by Hospital related to Members and necessary for payment of claims, including without limitation Confidential Information ("Information"); (b) Company (including Company's authorized designee), Government Sponsors and Federal, state, and local governmental authorities and their agents having jurisdiction, upon request, shall have access to all books, records and other papers (including, but not limited to, contracts, medical and financial records and physician incentive plan information) and information relating to this Agreement and to those services rendered by Hospital to Members ("Records"); (c) consistent with the consents and authorizations required by Section 2.5 hereof, Company or its agents or designees shall have access to medical records for the purpose of assessing quality of care, conducting medical evaluations and audits, and performing utilization management functions; (d) applicable Federal and state authorities and their agents shall have access to medical records for assessing the quality of care or investigating Member grievances or complaints; and (e) Members shall have access to their health information as required by 45 C.F.R. § 164.524 and applicable state law, be provided with an accounting of disclosures of information when and as required by 45 C.F.R. § 164.528 and applicable state law, and have the opportunity to amend or correct the information as required by 45 C.F.R. § 164.526 and applicable state law. Hospital agrees to supply copies of Information and Records within fourteen (14) days of the receipt of a request, where practicable, and in no event later than the date required by Government Sponsor directives and any applicable law or regulatory authority. This Section 5.3.2 shall survive the termination of this Agreement, regardless of the cause of termination.

5.3.3 Government Requirements Regarding Records for Medicare Members. In addition to the requirements of Sections 5.3.1 and 5.3.2, with respect to Medicare Plans, Hospital agrees to maintain Information and Records (as those terms are defined in Section 5.3) for the longer of: (i) ten (10) years from the end of the final contract period of any government contract of Company, (ii) the date the U.S. Department of Health and Human Services ("HHS"), the U.S. Comptroller General, or their designees complete an audit, or (iii) the period required by applicable laws, rules or regulations. Hospital further agrees that, with respect to Medicare Plans, Company and Federal, state and local government authorities having jurisdiction, or their designees, upon request, shall have access to all Information and Records, and that this right of inspection, evaluation and audit of Information and Records shall continue for the longer of (i) ten (10) years from the end of the final contract period of any government contract of Company, (ii) the date HHS, the U.S. Comptroller General, or their designee complete an audit, or (iii) the period required by applicable laws, rules or regulations. This Section 5.3.3 shall survive the termination of this Agreement, regardless of the cause of termination.

5.4 Quality, Accreditation and Review Activities.
Hospital agrees to cooperate with any Company quality activities or review of Company or a Plan conducted by the National Committee for Quality Assurance (NCQA) or a state or Federal agency with authority over Company and/or the Plan, as applicable.

5.5 Proprietary Information.

5.5.1 Rights and Responsibilities. Each Party agrees that the Proprietary Information of the other Party is the exclusive property of such Party and that each Party has no right, title or interest in the same. Each Party agrees to keep the Proprietary Information and this Agreement strictly confidential and agrees not to disclose any Proprietary Information or the contents of this Agreement to any third party without the other Party's consent, except (i) to governmental authorities having jurisdiction, (ii) in the case of Company's disclosure to Members, Government Sponsors, consultants and vendors under contract with Company, and (iii) in the case of Hospital's disclosure to Members for the limited purpose of advising Members of potential treatment options and costs consistent with applicable Federal and state laws. Except as otherwise required under applicable Federal or state law, each Party agrees to not use any Proprietary Information of the other Party, and at the request of the other Party hereto, return any Proprietary Information upon termination of this Agreement for whatever reason. Notwithstanding the foregoing, Hospital through its staff is encouraged to discuss Company's provider payment

methodology with patients, including descriptions of the methodology under which the Hospital is paid. In addition, Hospital through its staff may freely communicate with patients about their treatment options, regardless of benefit coverage limitations. This Section 5.5.1 shall survive the termination of this Agreement for one (1) year, regardless of the cause of termination.

6.0 TERM AND TERMINATION

6.1 Term.
This Agreement shall be effective for an initial term ("Initial Term") of one (1) year from the Effective Date, and thereafter shall automatically renew for additional terms of one (1) year each, unless and until terminated in accordance with this Article 6.0

6.2 Termination without Cause.
This Agreement may be terminated by Company at any time without cause with at least ninety (90) days prior written notice to Hospital. This Agreement may be terminated by Hospital without cause at any time following the conclusion of the Initial Term with at least ninety (90) days prior written notice to Company.

6.3 Termination for Breach.
This Agreement may be terminated at any time by either Party upon at least thirty (30) days prior written notice of such termination to the other Party upon material default or substantial breach by such Party of one or more of its obligations hereunder, unless such material default or substantial breach is cured within thirty (30) days of the notice of termination; provided, however, if such material default or substantial breach is incapable of being cured within such thirty (30) day period, any termination pursuant to this Section 6.3 will be ineffective for the period reasonably necessary to cure such breach if the breaching party has taken all steps reasonably capable of being performed within such thirty (30) day period. Notwithstanding the foregoing, the effective date of such termination may be extended pursuant to Section 6.6 herein.

6.4 Immediate Termination or Suspension.
Any of the following events shall result in the immediate termination or suspension of this Agreement by Company, upon notice to Hospital, at Company's discretion at any time: (a) the withdrawal, expiration or non-renewal of any Federal, state or local license, certificate, approval or authorization of Hospital; (b) the bankruptcy or receivership of Hospital, or an assignment by Hospital for the benefit of creditors; (c) the loss or material limitation of Hospital's insurance under Section 2.4 of this Agreement; (d) a determination by Company that Hospital's continued participation in provider networks could result in harm to Members; (e) the exclusion, debarment or suspension of Hospital from participation in any governmental sponsored program, including, but not limited to, Government Programs, Medicare or the Medicaid program in any state; (f) the indictment or conviction of Hospital for any crime; (g) the revocation or suspension of Hospital's accreditation by The Joint Commission or the Bureau of Hospitals of the American Osteopathic Association; (h) change of control of Hospital to an entity not acceptable to Company; or (i) the withdrawal, expiration or termination of the State Contract. To protect the interests of patients, including Members, Hospital will provide immediate notice to Company of any of the aforesaid events described in clauses (a) through (h), including notification of impending bankruptcy.

6.5 Obligations Following Termination.
Following the effective date of any expiration or termination of this Agreement or any Plan, Hospital and Company will cooperate as provided in this Section 6.5 and in Exhibits A and D, as applicable. This Section 6.5 and Exhibits A and D, as applicable shall survive the termination of this Agreement, regardless of the cause of termination.

6.5.1 Upon Termination. Company and Hospital desire to promote continuity of care. Accordingly, upon termination or non-renewal of this Agreement for any reason, other than termination by Company in accordance with Section 6.4 above, Hospital shall remain obligated at Company's request to provide Hospital Services to: (a) a pregnant Member in the third trimester of pregnancy, throughout the term of the Member's pregnancy; (b) any Member who is an inpatient at Hospital as of the effective date of termination until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (c) any Member, upon request of such Member or the applicable Plan Sponsor,

for one (1) calendar year. The terms of this Agreement, including the **Hospital Services and Compensation Schedule** shall apply to such services. Upon expiration or termination of this Agreement for any reason, other than termination by Company in accordance with Section 6.4 above, Hospital agrees to provide Hospital Services at Company's discretion to any Member who is an inpatient at Hospital as of the effective date of termination until such Member's discharge or Company's orderly transition of such Member's care to another provider and as otherwise required by applicable laws, government authorities or Government Sponsor directives. The terms of this Agreement, including the **Hospital Services and Compensation Schedule** shall apply to such services.

6.5.2 Upon Insolvency or Cessation of Operations. If this Agreement terminates as a result of insolvency or cessation of operations of Company, and as to Members of HMOs that become insolvent or cease operations, then in addition to other obligations set forth in this section, Hospital shall continue to provide Hospital Services to: (a) all Members for the period for which premium has been paid; and (b) Members confined as inpatients in Hospital on the date of insolvency or other cessation of operations until medically appropriate discharge. This provision shall be construed to be for the benefit of Members. No modification of this provision shall be effective without the prior written approval of the applicable regulatory agencies.

6.5.3 Obligation to Cooperate. Upon notice of expiration or termination of this Agreement or of a Plan, Hospital shall cooperate with Company and comply with Policies, if any, in the transfer of Members to other providers.

6.6 Obligations During Dispute Resolution Proceedings.
In the event of any dispute between the Parties in which a Party has provided notice of termination under Section 6.3 and the dispute is required to be resolved or is submitted for resolution under Article 8.0 below, the termination of this Agreement shall be stayed and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

7.0 RELATIONSHIP OF THE PARTIES

7.1 Independent Contractor Status.
The relationship between Company and Hospital, as well as their respective employees and agents, is that of independent contractors, and neither shall be considered an agent or representative of the other Party for any purpose, nor shall either hold itself out to be an agent or representative of the other for any purpose. Company and Hospital will each be solely liable for its own activities and those of its agents and employees, and neither Company nor Hospital will be liable in any way for the activities of the other Party or the other Party's agents or employees arising out of or in connection with: (a) any failure to perform any of the agreements, terms, covenants or conditions of this Agreement; (b) any negligent act or omission or other misconduct; (c) the failure to comply with any applicable laws, rules or regulations; or (d) any accident, injury or damage. Hospital acknowledges that all Member care and related decisions are the responsibility of Hospital and its medical staff, and that Policies do not dictate or control Hospital's clinical decisions with respect to the care of Members. Hospital agrees to indemnify and hold harmless the Government Sponsor and Company from any and all claims, liabilities and third party causes of action arising out of the Hospital's provision of care to Members. Company agrees to indemnify and hold harmless the Hospital from any and all claims, liabilities and third party causes of action arising out of the Company's administration of health care services in connection with the Plans. This provision shall survive the expiration or termination of this Agreement, regardless of the reason for termination.

7.2 Use of Name.
Hospital consents to the use of Hospital's name and other identifying and descriptive material in provider directories and in other materials and marketing literature of Company in all formats, including, but not limited to, electronic media. Hospital may use Company's names, logos, trademarks or service marks in marketing materials or otherwise, upon receipt of Company's prior written consent, which shall not be unreasonably withheld.

7.3 Interference with Contractual Relations.

Hospital shall not engage in activities that will cause Company to lose existing or potential Members, including but not limited to: (a) advising Company customers, Government Sponsors or other entities currently under contract with Company to cancel, or not renew said contracts; (b) impeding or otherwise interfering with negotiations which Company is conducting for the provision of health benefits or Plans; or (c) using or disclosing to any third party membership lists acquired during the term of this Agreement for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Notwithstanding the foregoing, Company shall not prohibit, or otherwise restrict, Hospital from advising or advocating on behalf of a Member who is its patient, for the following: (i) the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; (ii) any information the Member needs in order to decide among all relevant treatment options; (iii) the risks, benefits, and consequences of treatment or nontreatment; and (iv) the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. This section shall continue to be in effect for a period of one (1) year after the expiration or termination of this Agreement.

8.0 DISPUTE RESOLUTION

8.1 Member Grievance Dispute Resolution.

Hospital agrees to (a) cooperate with and participate in Company's applicable appeal, grievance and external review procedures (including, but not limited to, Medicaid appeals and expedited appeals procedures), (b) provide Company with the information necessary to resolve same, and (c) abide by decisions of the applicable appeals, grievance and review committees. Company will make available to Hospital information concerning the Member appeal, grievance and external review procedures at the time of entering into this Agreement.

8.2 Provider Dispute Resolution.

Company shall provide a mechanism whereby Hospital may raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Hospital shall exhaust this mechanism prior to instituting any arbitration or other permitted legal proceeding. The Parties agree that any dispute that may arise between the Parties shall not disrupt or interfere with the provision of services to Members. Discussions and negotiations held pursuant to this Section 8.2 shall be treated as inadmissible compromise and settlement negotiations for purposes of applicable rules of evidence.

8.3 Arbitration.

8.3.1 Submission of Claim or Controversy to Arbitration. Any controversy or claim arising out of or relating to this Agreement or the breach, termination, or validity thereof, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration administered by the American Arbitration Association ("AAA") and conducted by a sole Arbitrator ("Arbitrator") in accordance with the AAA's Commercial Arbitration Rules ("Rules"). The arbitration shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16, to the exclusion of state laws inconsistent therewith or that would produce a different result, and judgment on the award rendered by the Arbitrator (the "Award") may be entered by any court having jurisdiction thereof. A stenographic record shall be made of all testimony in any arbitration in which any disclosed claim or counterclaim exceeds $250,000. An Award for $250,000 or more shall be accompanied by a short statement of the reasoning on which the Award rests.

8.3.2 Appeal of Arbitration Award. In the event a Party believes there is a clear error of law and within thirty (30) days of receipt of an Award of $250,000 or more (which shall not be binding if an appeal is taken), a Party may notify the AAA of its intention to appeal the Award to a second Arbitrator (the "Appeal Arbitrator"), designated in the same manner as the Arbitrator except that the Appeal Arbitrator must have at least twenty (20) years' experience in the active practice of law or as a judge. The Award, as confirmed, modified or replaced by the Appeal Arbitrator, shall be final and binding, and judgment thereon may be entered by any court having jurisdiction thereof. No other arbitration appeals may be made.

8.3.3 Confidentiality. Except as may be required by law or to the extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an Award, neither a Party nor an arbitrator may disclose the existence, content, record, status or results of a negotiation or arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to a negotiation or arbitration, or reflecting the existence, content, record, status, or results of a negotiation ("Negotiation Record") or arbitration ("Arbitration Record"), is confidential. The arbitration hearing shall be closed to any person or entity other than the arbitrator, the parties, witnesses during their testimony, and attorneys of record. Upon the request of a Party, an arbitrator may take such actions as are necessary to enforce this Section 8.3.3, including the imposition of sanctions.

8.3.4 Pre-hearing Procedure for Arbitration. The Parties will cooperate in good faith in the voluntary, prompt and informal exchange of all documents and information (that are neither privileged nor proprietary) relevant to the dispute or claim, all documents in their possession or control on which they rely in support of their positions or which they intend to introduce as exhibits at the hearing, the identities of all individuals with knowledge about the dispute or claim and a brief description of such knowledge, and the identities, qualifications and anticipated testimony of all experts who may be called upon to testify or whose report may be introduced at the hearing. The Parties and Arbitrator will make commercially reasonable efforts to conclude the document and information exchange process within sixty (60) calendar days after all pleadings or notices of claims have been received. At the request of a Party in any arbitration in which any disclosed claim or counterclaim exceeds $250,000, the Arbitrator may also order pre-hearing discovery by deposition upon good cause shown. Such depositions shall be limited to a maximum of three (3) per Party and shall be limited to a maximum of six (6) hours' duration each. As they become aware of new documents or information (including experts who may be called upon to testify), all Parties remain under a continuing obligation to provide relevant, non-privileged documents, to supplement their identification of witnesses and experts, and to honor any understandings between the Parties regarding documents or information to be exchanged. Documents that have not been previously exchanged, or witnesses and experts not previously identified, will not be considered by the Arbitrator at the hearing. Fourteen (14) calendar days before the hearing, the Parties will exchange and provide to the Arbitrator (a) a list of witnesses they intend to call (including any experts) with a short description of the anticipated direct testimony of each witness and an estimate of the length thereof, and (b) premarked copies of all exhibits they intend to use at the hearing.

8.3.5 Arbitration Award. The arbitrator may award only monetary relief and is not empowered to award damages other than compensatory damages and, in the arbitrator's discretion, pre-award interest. The Award shall be in satisfaction of all claims by all Parties. Arbitrator fees and expenses shall be borne equally by the Parties. Postponement and cancellation fees and expenses shall be borne by the Party causing the postponement or cancellation. Fees and expenses incurred by a Party in successfully enforcing an Award shall be borne by the other Party. Except as otherwise provided in this Agreement, each Party shall bear all other fees and expenses it incurs, including all filing, witness, expert witness, transcript, and attorneys' fees.

8.3.6 Survival. The provisions of Section 8.3 shall survive expiration or termination of this Agreement, regardless of the cause giving rise hereto.

8.4 Arbitration Solely Between Parties; No Consolidation or Class Action.
Company and Hospital agree that any arbitration or other proceeding related to a dispute arising under this Agreement shall be conducted solely between them. Neither Party shall request, nor consent to any request, that their dispute be joined or consolidated for any purpose, including without limitation any class action or similar procedural device, with any other proceeding between such Party and any third party.

9.0 MISCELLANEOUS

9.1 Amendments.

This Agreement constitutes the entire understanding of the Parties hereto and no changes, amendments or alterations shall be effective unless signed by both Parties, except as expressly provided herein. Company may amend this Agreement upon thirty (30) days prior written notice, by letter, newsletter, electronic mail or other media (an "Amendment"). Failure by Hospital to object in writing to any such Amendment within thirty (30) days following receipt thereof constitutes Hospital's acceptance of such Amendment. In the event that Hospital reasonably believes that an Amendment is likely to have a material adverse impact upon Hospital, Hospital agrees to notify Company in writing, specifying the specific bases demonstrating a likely material adverse impact, and the Parties will negotiate in good faith an appropriate revised Amendment, if any, to this Agreement. Notwithstanding the foregoing, at Company's discretion, Company may amend this Agreement to comply with applicable law or regulation, or any order or directive of any governmental agency, without the consent of Hospital, and this Agreement shall be deemed to be automatically amended to conform with all laws and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over this Agreement. Hospital agrees that noncompliance with any requirements of this Section 9.1 will relieve Company or Government Sponsors and Members from any financial liability for the applicable portion of the Hospital Services. Changes to Policies are addressed by Section 5.1 hereto.

9.2 Waiver.
The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, all waivers must be in writing and signed by an authorized officer of the Party to be charged. Hospital waives any claims or cause of action for fraud in the inducement or execution related hereto.

9.3 Governing Law.
This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State of Iowa.

9.4 Liability.
Notwithstanding Section 9.3, either Party's liability, if any, for damages to the other Party for any cause whatsoever arising out of or related to this Agreement, and regardless of the form of the action, shall be limited to the damaged Party's actual damages. Neither Party shall be liable for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whatsoever sustained as a result of a breach of this Agreement or any action, inaction, alleged tortious conduct, or delay by the other Party.

9.5 Severability.
Any determination that any provision of this Agreement or any application thereof is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Neither Party shall assert or claim that this Agreement or any provision hereof is void or voidable if such Party performs under this Agreement without prompt and timely written objection.

9.6 Successors; Assignment.
This Agreement relates solely to the provision of Hospital Services by Hospital and does not apply to any other organization which succeeds to Hospital assets, by merger, acquisition or otherwise, or is an affiliate of Hospital. Neither Party may assign its rights or its duties and obligations under this Agreement without the prior written consent of the other Party, which consent may not be unreasonably withheld; provided, however, that Company may assign its rights or its duties and obligations to an Affiliate or successor in interest so long as any such assignment or delegation will not have a material impact upon the rights, duties and obligations of Hospital.

9.7 Headings.
The headings contained in this Agreement are included for purposes of convenience only, and shall not affect in any way the meaning or interpretation of any of the terms or provisions of this Agreement.

9.8 Notices.
Except for any notice required under Article 6, Term and Termination, or if otherwise specified, notices required pursuant to the terms and provisions hereof may be effective if sent by letter, electronic mail or other generally accepted media. With respect to notices required under Article 6, notice shall be effective only if given in writing and sent by overnight delivery service with proof of receipt, or by certified mail return receipt requested. Notices shall be sent to the addresses set forth on the signature page of this Agreement (which addresses may be changed by giving notice in conformity with this Section 9.8). Hospital shall notify Company of any changes in the information provided by Hospital related to Hospital's address.

9.9 Remedies.
Notwithstanding Sections 8.3 and 9.4, the Parties agree that each has the right to seek any and all remedies at law or equity in the event of breach or threatened breach of Section(s) 5.5, 6.6 and 7.3.

9.10 Non-Exclusivity.
This Agreement is not exclusive, and nothing herein shall preclude either Party from contracting with any other person or entity for any purpose. Company makes no representation or guarantee as to the number of Members who may select or be assigned to Hospital.

9.11 Force Majeure.
If either Party shall be delayed or interrupted in the performance or completion of its obligations hereunder by any act, neglect or default of the other Party, or by an embargo, war, act of terror, riot, incendiary, fire, flood, earthquake, epidemic or other calamity, act of God or of the public enemy, governmental act (including, but not restricted to, any government priority, preference, requisition, allocation, interference, restraint or seizure, or the necessity of complying with any governmental order, directive, ruling or request) then the time of completion specified herein shall be extended for a period equivalent to the time lost as a result thereof. This Section 9.11 shall not apply to either Party's obligations to pay any amounts owing to the other Party, nor to any strike or labor dispute involving such Party or the other Party.

9.12 Confidentiality.
It is further understood and agreed by and among the Parties that the terms and conditions of this Agreement, except as otherwise specified, are and shall remain confidential, and shall not be disclosed by either Party without express written consent of the other Party or as required by law or by governmental authorities or by express order by a court having jurisdiction over the Party from whom disclosure is sought.

9.13 Entire Agreement.
This Agreement (including any attached schedules, appendices and/or addenda) constitutes the complete and sole contract between the Parties regarding the subject matter described above and supersedes any and all prior or contemporaneous oral or written representations, communications, proposals or agreements not expressly included in this Agreement and may not be contradicted or varied by evidence of prior, contemporaneous or subsequent oral representations, communications, proposals, agreements, prior course of dealings or discussions of the Parties. The Parties understand and agree that this Agreement only applies to the Plans described in this Agreement and, likewise, this Agreement does not and will not supersede any agreement(s) between Company's affiliates and Provider that relates to Company's affiliates other lines of business that are not the subject of this Agreement (that are not the Plans described in this Agreement).

9.14 Signatures. Facsimile and electronic signatures shall be deemed to be original signatures for all purposes of this Agreement.

9.15 Incorporation of Recitals. The Parties incorporate the recitals into this Agreement as representations of fact to each other.

Remainder of page intentionally left blank. Signature page follows.

IN WITNESS WHEREOF, the undersigned parties have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.

Hospital Sign Here

HOSPITAL	**COMPANY**
By:_____	By:_____
Printed Name:_____	Printed Name:_____
Title:_____	Title:_____
Date:_____	Date:_____

REIMBURSEMENT ADDRESS:

_____
_____
_____

MAIN TELEPHONE NUMBER:_____

CHIEF EXECUTIVE OFFICER:_____

CHIEF FINANCIAL OFFICER:_____

BUSINESS OFFICE MANAGER:_____

FEDERAL TAX I.D. NUMBER:_____

NPI NUMBER:_____

As required by Section 9.8 ("Notices") of this Agreement, notices shall be sent to each Party at the following addresses:

To Hospital at:
_____
_____
_____
_____
_____

To Company at:

Aetna Better Health of Iowa
Attn: Network Management
4320 NW 114th Street
Urbandale, IA 50322

With a copy to**:**
Aetna
Law Dept, Medicaid, Mail Code RE6A
151 Farmington Avenue
Hartford, CT 06156-0001

PROGRAM PARTICIPATION SCHEDULE

Hospital agrees to participate in the Plans and other health benefit programs listed herein upon issuance of any required licenses and contracts to Company:

Iowa Medicaid managed care Plans offered by Aetna Better Health of Iowa Inc., pursuant to contract with the Iowa Department of Human Services for delivery of high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa hawk-i programs.

SERVICES AND COMPENSATION SCHEDULE

1.0 COMPENSATION

Iowa Medicaid, CHIP & QHP Plans:	Aetna Medicaid Market Fee Schedule
Iowa Medicare Plans:	Medicare Allowable Rate

2.0 SERVICES

Provider will be reimbursed for those Covered Services in accordance with the terms of this Agreement that are within the scope of and appropriate to the Provider's license and certification to practice.

3.0 GENERAL COMPENSATION TERMS AND CONDITIONS

Definitions

"Aetna Medicaid Market Fee Schedule (AMMFS)" – A fee schedule that is based upon the contracted location where service is performed and the State of Iowa's Medicaid Fee Schedule.

"Medicare Allowable" - the current payment as of discharge date that a hospital will receive from Company, subject to the then current Medicare Inpatient Prospective Payments Systems and will be updated in accordance with CMS changes, provided, however, that exempt units for psychiatric, rehabilitation and skilled nursing facility services will be paid in accordance with the applicable Medicare Prospective Payment Systems. These payments are intended to mirror the payment a Medicare Fiscal Intermediary ("FI") would make to the hospital, less (with respect to DRG-based payments) the payments for Indirect Medical Education (IME), Direct Graduate Medical Education (DGME), bad debt, as appropriate and adjusted by CMS or Government Sponsor for sequestration, SGR or other items and Aetna payment and processing guidelines. For other provider types, the Medicare allowable rate is based upon CMS Geographic Pricing Cost Indices (GPCI) and Resource Based Relative Value Scale (RBRVS) Relative Value Units (RVU) including Outpatient Prospective Payment System (OPPS) cap rates; the Clinical Laboratory Fee Schedule (CLAB); the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule; including PEN (DMEPOS) and 'Medicare Part B Drug Average Sales Price (ASP),' as appropriate. Coding and fees determined under this schedule will be updated as CMS releases code updates, changes in the MFS relative values, including OPPS cap payments, or the CMS conversion factors. Company plans to update the schedule within 90 days of the final rates and/or codes being published by CMS. However, the rates and coding sets for these services do not become effective until updates are completed by Company and payment is considered final and exclusive of any retroactive or retrospective CMS adjustments to the rate. Company payment policies apply to services paid based upon the Medicare allowable rate.

General

A. Member Cost Share. Rates are inclusive of any applicable Member Copayment, Coinsurance or Deductible.

B. Billing. When billing, Hospital must designate applicable codes related to those Covered Services provided by Hospital under the terms of this Agreement.

C. Coding. Company utilizes nationally recognized coding structures including, but not limited to, Revenue Codes as described by the Uniform Billing Code, AMA Current Procedural Terminology (CPT4), CMS Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), IDC-9 (or successor standard) Diagnosis and Procedure codes, and National Drug Codes (NDC). As changes are made to nationally-recognized codes, Company will update internal systems to accommodate new codes. Such changes will only be made when there is

no material change in the procedure itself. Until updates are complete, the procedure will be paid according to the standards and coding set for the prior period.

The use of ICD-10 coding shall not impact the aggregate rates and compensation intended by the Parties as set forth in this Services and Compensation Schedule. Consequently, in the event that use of ICD-10 codes result in aggregate payments that would differ from the aggregate payments that would have resulted based on ICD-9 coding (excluding utilization and validated case mix severity changes), the rates set forth in this Services and Compensation Schedule will be reviewed by Company periodically and adjusted at least annually in order to reflect what would have been paid had ICD-9 coding been utilized for determination of the payments.

Company will comply and utilize nationally recognized coding structures as directed under applicable Federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act (HIPAA).

D. Affordable Care Act Primary Care Enhancement. For those primary care Covered Services that the State of Iowa has determined to reimburse at 100% of the Medicare allowable amount in accordance with Section 1902(a)(13)(C) of the Social Security Act, for so long as the rates are in effect and so long as Hospital meets the requirements of applicable law for the rates, Company shall compensate Hospital for the provision of such Covered Services to eligible Members delivered in accordance with the terms and conditions set forth in this Agreement at the lesser of Hosptial's billed charges or an amount equal to but not greater than the State's enhanced rates. Hospital certifies that, to the extent required by law, such payments will insure to the benefit of the individual Participating Physicians, and will supply Company with any legally-required documentation of such. Company reserves the right i) to pay such enhanced compensation through monthly or quarterly_adjustment; ii) to make payments directly to qualifying Participating Physicians; and/or iii) to require such Physicians or Hospital to complete any agreements, forms, attestations or releases needed to effectuate such payments. Enhanced compensation is not available for Members of CHIP Plans.

E. Medicare-Medicaid Dual-Eligibles – Where Company is the responsible payor for Medicare and Medicaid Covered Services, rates for each service are determined by whether that service is regarded as a Medicare Covered Service or a Medicaid Covered Service by CMS and Government Sponsor, and with respect to a Member's benefit limits under each program. For Medicare Covered Services (inclusive of Member Copayment or Coinsurance), Company shall compensate provider at the specified Medicare rate. For Medicaid Covered Services, Company shall compensate provider according to the applicable Medicaid rate. When a service is covered under Medicare and Medicaid, Company will determine the rate (Medicare or Medicaid) according to applicable law, coordination of benefit principles and the terms of Member's Plan. Rates do not include, and Company is not responsible for, supplemental or wrap-around payments unless required by Company's contracts with Government Sponsor.

Exhibit A

Iowa Regulatory Compliance Addendum

This Regulatory Compliance Addendum is incorporated by reference into the Agreement. It applies to Iowa Medicaid managed care plans offered by Better Health of Iowa Inc. ("Company"), pursuant to contract with the Iowa Department of Human Services (DHS) for delivery of high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa hawk-i programs and the eligible populations covered by the State Contract between Company and DHS. This Addendum is effective as of the Effective Date of the Agreement.

Provider agrees that all applicable terms and conditions set out in the RFP, the State Contract, any incorporated documents and all applicable state and federal laws, as amended, govern the duties and responsibilities of the Provider with regard to the provision of services to members in the programs applicable hereto. The RFP and State Contract may currently be found at: http://bidopportunities.iowa.gov/?pgname=viewrfp&rfp_id=11140

If there is any conflict between the terms of this Addendum and any of the other terms of the Agreement, including any attachments, schedules, exhibits and/or addenda made part of the Agreement, the terms of this Addendum will govern and control; provided, however, if there is any conflict between any of the terms of the Agreement, including this Addendum, and the State Contract, then the terms of the State Contract will govern and control. For purposes of this Regulatory Compliance Addendum, the term "Provider" shall mean the health care physician, provider, group, facility or hospital executing the Agreement, as identified on the first page of the Agreement.

1.0 DEFINITIONS [taken from the RFP Glossary]

When used in this Agreement, all capitalized terms shall have the following meanings:

Children's Health Insurance Program ("CHIP"). The program created in 1997 by Title XXI of the Social Security Act and known in Iowa as CHIP.

Claim. A formal request for payment for benefits received or services rendered.

CMS. The Centers for Medicare and Medicaid Services.

Co-Payment. A cost-sharing arrangement in which a Member pays a specified charge for a specified service; also called a co-pay.

Covered Services. Those health care services/benefits to which an individual eligible for Medicaid/CHIP is entitled under the Iowa Medicaid State Plan and which Company is required to provide or arrange for pursuant to the State Contract.

IDPH. Iowa Department of Public Health.

IDPH Participants. A resident of the State of Iowa with an income at or below 200% of the federal poverty guidelines as published by the Department of Health and Human Services who is not insured or for whom third party payment is not available to pay for services. An Iowa Medicaid member shall not be an IDPH Participant. An Iowa Health and Wellness Plan member may be an IDPH Participant for those IDPH-funded substance use disorder services that are not fully covered by the Iowa Health and Wellness Plan.

Iowa Department of Human Services ("DHS"). The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Iowa.

Iowa Medicaid State Plan. The binding written agreement between DHS and CMS, which describes how the Medicaid program is administered and determines the services for which DHS will receive federal financial participation.

Medicaid. A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act Amendment. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving covered individuals.

Medical Records. All medical, behavioral health, and long-term care histories; records, reports and summaries; diagnoses; prognoses; record of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, behavioral health, and long-term care documentation in written or electronic format; and analyses of such information.

Medically Necessary Services. Those Covered Services that are, under the terms and conditions of the State Contract, determined through Company utilization management to be:

(1) Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the Member;

(2) Provided for the diagnosis or direct care and treatment of the condition of the Member enabling the Member to make reasonable progress in treatment;

(3) Within standards of professional practice and given at the appropriate time and in the appropriate setting;

(4) Not primarily for the convenience of the Member, the Member's physician or other provider; and

(5) The most appropriate level of Covered Services, which can safely be provided.

Member. A Medicaid recipient who is subject to mandatory enrollment or is currently enrolled in Company's coverage under the State Contract.

Policies. In addition to the policies and procedures promulgated by Company, which relate to the duties and obligations of the Parties under the terms of the Agreement, Policies include the general principles by which DHS is guided in its management of the Title XIX program, as further set forth and defined by DHS promulgations and by state and federal rules and regulations.

Provider Preventable Conditions. Situations in which Medicaid payment is prohibited for services that should have been avoidable as defined in 42 CFR §447.26.

State Contract. The written agreement between Company and DHS, a copy of which may be found by Provider on the State's website. The State Contract is comprised of and incorporates all provisions of the RFP and any addenda, appendices, attachments or amendments thereto, as well as any Member handbook, provider handbook and/or other applicable policy guides, manuals and materials.

2.0 PROVIDER SERVICES AND OBLIGATIONS

2.1 Medical Necessity.
Provider agrees that for the purposes of Covered Services to Members, "Medically Necessary Services" shall be as defined above in this Addendum.

2.2 Timely Access.
Provider must meet the standards for timely access to care and services for Members as set forth on Exhibit B to the RFP, taking into account the urgency of the need for services. Provider must offer hours of operation to Members that are no less than the hours of operation offered to other non-Medicaid patients, or if Provider serves only Medicaid beneficiaries, hours of operation comparable to the hours of operation offered to enrollees of any Iowa Medicaid Fee for Service Program. Provider agrees to provide Covered Services to Members on a twenty-four (24) hour per day, seven (7) day per week basis. [42 CFR 438.209]

2.3 Inability To Pay Co-Payment.

Provider shall not deny care or services to any Member because of the Member's inability to pay the Co-Payment. [RFP SOW §5.3.5]

2.4 Medical Records.

Provider shall create and maintain Medical Records for Members in accordance with applicable law including, but not limited to, Iowa Administrative Code Title 441, Chapter 79.3 and Policies. Without limiting the foregoing, Provider's records must be maintained in a manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical Records must be legible, signed, dated and maintained as required by law. Provider shall provide a copy of the Member's Medical Record to the Member upon reasonable request by the Member at no charge. Provider shall facilitate the transfer of a Member's Medical Record to another provider at the Member's request. Provider must maintain the confidentiality of and access to Medical Records in accordance with the standards mandated in the Health Insurance Portability and Accountability Act and all other state and federal requirements. Provider shall permit Company, representatives of DHS, and other authorized entities to review Members' Medical Records for purpose of monitoring Provider's compliance with the record standards, capturing information for clinical studies, monitoring quality or any other reason. Without limiting the foregoing, Provider will release mental health information regarding Members only as allowed by Iowa Code §228. [RFP SOW §6.1.9 & 2.15]

2.5 Member Rights.

Provider shall take Members' rights as set forth in law into account when providing services to Members. Such rights include the right to receive information as set forth in 42 CFR §438.100, the right to be treated with respect and with due consideration for his or her dignity and privacy; the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand; the right to participate in decisions regarding his or her health care, including the right to refuse treatment; the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion; the right to treatment in the least restrictive setting; the right to fully participate in the community and to work, live and learn to the fullest extent possible; and the right to be furnished health care services in accordance with 42 CFR §§438.206 through 438.210. [RFP SOW §1.4.1]

2.6 Critical Incidents.

If Provider is a provider who has personal contact with Members under the Home-and-Community-Based Services (HCBS) habilitation and waiver services, Provider shall (i) report critical incidents; (ii) respond to critical incidents; (iii) document critical incidents; and (iv) cooperate with any investigation conducted by Company or an outside agency. Provider shall complete any critical incident training required by Company. [RFP SOW §10.4.2]

2.7 Enforcement of §6032 of the 2005 Deficit Reduction Act (DRA).

If Provider receives five million dollars ($5,000,000) or more in Medicaid payments in a federal fiscal year, Provider shall have written policies for all employees, including management, and for all employees of any contractor or agent, that provide detailed information about the following: [RFP SOW §12.12]

a. The Federal False Claims Act under title 31 of the United States Code, sections 3729 through 3733;

b. Administrative remedies for false claims and statements under title 31 of the United States Code, chapter 38;

c. Any State laws pertaining to civil or criminal penalties for false claims and statements (Iowa Code 249A.8 and 714.8(10)-714.14);

d. Whistleblower protections under such laws; and

e. The Provider's policies and procedures for detecting and preventing fraud, waste, and abuse.

2.8 Additional Duties For Nursing Facilities. If Provider is a nursing facility, Provider shall: [RFP SOW §6.1.2.1]

a. Promptly notify Company of a Member's admission or request for admission to the nursing facility as soon as the facility has knowledge of such admission or equest for admission;

b. Notify the Company immediately if the nursing facility is considering discharging a Member and to consult with the Member's care coordinator;

c. Notify the Member and/or the Member's representative (if applicable) in writing prior to discharge in accordance with state and federal requirements;

d. Collect from any Member the Member's patient liability amount as communicated to Provider by Company. Provider agrees that payments from Company to Provider will be net of the applicable patient liability amount for any Member with patient liability.

e. Notify Company of any change in a Member's medical or functional condition that could impact the Member's level of care eligibility for the currently authorized level of nursing facility services;

f. Comply with federal Preadmission Screening and Resident Review ("PASRR") requirements to provide or arrange to provide specialized services and all applicable Iowa law governing admission, transfer and discharge policies; and

g. hereby agrees that the Agreement will automatically be terminated in accordance with federal requirements if Provider is involuntarily decertified by the State or CMS.

2.9 Additional Duties for Home and Community-Based Services. If Provider provides Home and Community-Based Services, Provider shall: [RFP SOW §6.1.2.2]

a. Provide at least thirty (30) days advance notice to the Company when the Provider is no longer willing or able to provide services to a Member and to cooperate with the Member's care coordinator to facilitate a seamless transition to alternate providers;

b. In the event that a HCBS provider change is initiated for a Member, regardless of any other provision in Agreement, continue to provide services to the Member in accordance with the Member's plan of care until the Member has been transitioned to a new provider, as determined by the Company, or as otherwise directed by the Company, which may exceed thirty (30) days from the date of notice to the Company;

c. Immediately report any deviations from a Member's service schedule to the Member's care coordinator;

d. Comply with the critical incident reporting requirements.

e. Comply with all child and dependent adult abuse reporting requirements.

2.10 Additional Duties for Community-Based Services Providers For Resident Transfer and Discharge. Neither Company nor Provider shall transition nursing facility, ICF/ID, 1915(i) Habilitation or 1915(c) community-based residential alternative residents to another facility or residence unless: (i) the Member or

his/her representative specifically requests to transition; (ii) the Member or his/her representative provides written consent to transition based on quality or other concerns raised by the Company or Provider, which shall not include the residential provider's rate of reimbursement; or (iii) the provider has chosen not to contract with the Company. The Company shall establish contractual terms with its providers, subject to approval by DHS, that protects an individual from involuntary discharge that may lead to a placement in an inappropriate or more restrictive setting. The Company shall facilitate a seamless transition whenever a Member transitions between facilities or residences. [RFP SOW §4.3.10]

2.11 Additional Duties for Providers with IDPH Participants.
If Provider provides services to IPDH Participants who are intravenous ("IV") drug users, Provider shall perform outreach activities. Provider shall select, train and supervise outreach workers. Provider shall encourage individuals needing IV treatment to undergo treatment and provide awareness about the relationship between IV drug use and communicable disease. Provider shall use outreach models that are applicable to the local situation and use an approach that can be expected to be reasonably effective. [RFP SOW §3.2.8.15]

2.12 Additional Duties for IHH Providers.
If Provider provides integrated health homes services, Provider agrees to provide the following: (i) quality-driven, cost-effective, culturally appropriate, and person-and family-driven health home services; (ii) high-quality health care services informed by evidence-based clinical practice guidelines; (iii) preventive and health promotion services informed by evidence-based clinical practice guidelines; (iv) preventive and health promotion services, including prevention of mental illness and substance use disorders; (v) comprehensive care management, care coordination and transitional care across settings; (vi) chronic disease management, including self-management support to Members and their families; (vii) demonstrating a capacity to use health information technology to link services, facilitate communication among team members and between the health home team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and (viii) establishing a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level. [RFP SOW §3.2.9.1.2]

3.0 CLAIMS SUBMISSION, COMPENSATION AND MEMBER BILLING

3.1 Timely Filing.
Provider shall submit all Claims that do not involve a third party payer, to Company within ninety (90) days of the date of service. [RFP SOW §6.1.2]

3.2 Cost Sharing and Patient Liability.
Provider shall not require any cost sharing or patient liability responsibilities for Covered Services except to the extent that cost sharing or patient liabilities are required for those services in accordance with law and the Agreement. [RFP SOW §3.2.15.3]

3.3 Third Party Liability.
Provider shall identify any third party liability coverage available to a Member, including Medicare and long-term care insurance, as applicable, and except as otherwise required, seek such third party liability payment before submitting Claims to Company. [RFP SOW §6.1.2]

3.4 Payment Net of Co-Payment.
Provider acknowledges and agrees that Company shall reduce the amount of payment it makes to Provider by the amount of the Member's Co-Payment obligation regardless of whether Provider has collected or waived the Co-Payment, except as provided in 42 C.F.R. §447.56(c). [RFP SOW §5.3.6]

3.5 Missed Appointments.
Provider shall not charge Members for missed appointments. [RFP SOW §3.2.15.3]

3.6 IDPH Participant Substance Use Disorder Services.

If and to the extent Provider provides substance use disorder services to IDPH Participants, Provider agrees to accept payment from the IDPH Participant according to the IDPH-approved siding fee schedule for such substance use disorder services. Providers billing and collection procedures for IDPH Participants shall be consistent with those established and provided by the IDPH. Provider agrees that services funded partially or completely by IDPH shall not be denied to a person because of the inability of the person or group to pay a fee for the service. Further, Provider shall not charge and IDPH Participant for missed appointments; provided, however, that Provider may charge the IDPH Participant a one-time no-show fee in an amount not to exceed that established by the IDPH. Provider acknowledges and agrees that IDPH funds are the payment of last resort for substance use disorder services provided to IDPH Participants and shall comply with IDPH and Company policies on IDPH eligibility for person with insurance coverage. [RFP SOW §5.5 & 13.6.4]

3.7 Provider Preventable Conditions.

Provider acknowledges and agrees that Company shall not make payment to Provider for a Provider Preventable Condition. This includes health-acquired conditions as identified by Medicare other than deep vein thrombosis and pulmonary embolism following total knee replacement or hip replacement surgery in pediatric and obstetric patients. Company shall also not make payment for wrong surgical or other invasive procedure on a patient or surgical, other invasive procedure performed on the wrong body part or wrong patient or any future additional to the list of non-reimbursable Provider Preventable Conditions. As a condition of payment under the Agreement, Provider agrees to comply with the reporting requirements for Provider Preventable Conditions found at 42 CFR §447.26(d). [RFP SOW §10.5]

4.0 GENERAL PROVISIONS

4.1 Debarred Individuals.

Provider represents and warrants that Provider is not and at no time has been (i) a person debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or (ii) an affiliate, as defined in the Federal Acquisition Regulation, of a person described in subsection (i) above. Provider shall immediately notify Company if at any time this representation and warranty is no longer accurate. [RFP SOW §2.6]

Exhibit D

Medicare Compliance Addendum

Without limiting any obligation of Provider under the Agreement, Provider agrees to the requirements set forth in this Addendum. Capitalized terms not otherwise defined herein, including within Schedule 1 attached hereto, shall have the meanings ascribed to them in the Agreement.

1. DESCRIPTION. This Addendum includes any Medicare plan(s) offered by Company to Medicare beneficiaries under a contract with the Centers for Medicare and Medicaid Services pursuant to Part C of Title XVIII of the Social Security Act ("Medicare Plans"). The Medicare Plans included in this Addendum do NOT include any Medicare Advantage plan(s) that the Company has deemed to be Medicare High Performance Network plans. From time to time Company and/or Payers may designate only certain Participating Providers to take part in the provider delivery network for a particular Product benefit plan(s).

2. PAYMENT.
A. In consideration of Provider's agreement to perform Covered Services in accordance with the Agreement, Provider shall be paid for Covered Services performed according to the terms of the applicable Service and Rate Schedule.

B. Company shall not pay any amounts beyond the amounts set forth in the applicable Service & Rate Schedule, including but not limited to any incentive payments that may be payable under traditional Medicare, except as expressly required by the Agreement or applicable law. Further, the Parties acknowledge and agree that payments under the Medicare program to providers, suppliers, and Medicare Advantage organizations may be adjusted as the result of legislation, regulation, executive order or other federal mandate ("Medicare Payment Adjustment"). Furthermore, any such Medicare Payment Adjustment could result in an increase or decrease in Medicare payments. In accordance with the terms of this Agreement, the Parties agree that, in the event of a Medicare Payment Adjustment, Company's payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. Company shall adjust payments under this Agreement for Covered Services rendered by Provider on and after the effective date of the Medicare Payment Adjustment, and shall continue to adjustment payments to Provider for until the earlier of (i) the Medicare Payment Adjustment is discontinued or (ii) is replaced by a subsequent Medicare Payment Adjustment.

C. Pursuant to Section 6.K. of this Addendum, Provider certifies that the diagnosis codes submitted to Company for Medicare Members that Company is required to submit to CMS will be accurate, complete and truthful ("Certification"). Provider acknowledges and agrees that Company may impose a penalty on Provider not to exceed five thousand dollars ($5,000) for each instance that Provider submits a diagnosis code to Company for a Medicare Member that does not comply with this Certification because the diagnosis code was not submitted in the format described in 42 C.F.R. § 422.310 or any subsequent or additional federal regulations. For purposes of this Section 2, "diagnosis code" shall mean an International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) code or its successor.

D. Federal laws and regulations limit the timeframe within which CMS may recover overpayments made to physicians, providers, and suppliers who submit claims to Medicare contractors (such as fiscal intermediaries, regional home health intermediaries, carriers, Medicare Administrative Contractors, and Durable Medical Equipment Medicare Administrative Contractors) for services provided or supplied to Medicare beneficiaries enrolled in Original Medicare ("Medicare Statute of Limitations"). If Company makes an overpayment or payment in error to Provider for Medicare Members, Company shall have the right to initiate overpayment recovery efforts within the same timeframe available to CMS under the Medicare Statute of Limitations; provided that no time limit shall apply to initiation of overpayment recovery efforts based on Company's reasonable suspicion of fraud or other intentional misconduct.

3. ASSIGNMENT. In addition to all other rights of Company under the Agreement, the Agreement (including, but not limited to, as it relates to the line(s) of business described in this Addendum) may be assigned by Company, at any time and from time to time, in whole or in part, to any other affiliate or successor in interest. At Company's option, the Agreement shall survive, without any other change in its terms, as a distinct, separate agreement with

Company for those products/lines of business designated by Company and in duplicate form as a separate, distinct participating provider agreement with the applicable affiliate(s)/successor(s) for the products/lines of business assigned to such entity(ies). In the event of any assignment under this paragraph, Company shall provide advance written notice to Provider. In the event of a conflict between this paragraph and any other provision of the Agreement, the terms of this paragraph shall supersede and prevail.

4. EFFECT OF TERMINATION. In the event this Addendum is terminated for any reason, such termination shall not constitute termination of any of Company's other products, plans or programs.

5. MEDICARE REQUIRED PROVISIONS. Provider agrees to comply with all of the provisions of Schedule 1, attached hereto and incorporated into this Addendum.

6. PROVIDER OBLIGATIONS.
A. Provision of Covered Services. Provider agrees to provide to Medicare Members the health care services for which Provider is licensed and customarily provides in accordance with accepted medical and surgical standards in the community. Provider shall make Covered Services available and accessible to Medicare Members, including telephone access to Provider, on a twenty-four (24) hours, seven (7) days per week basis.

B. Provider agrees that all Medicare Services and other activities performed by Provider under the Agreement will be consistent and comply with Company's obligations as a Medicare Advantage Organization under Company's contracts with CMS. Upon request, Provider shall immediately provide to Company any information that is required by Company to meet its reporting obligations to CMS, including without limitation, physician incentive plan information, if applicable. To the extent that Provider generates and/or compiles and provides any data to Company that Company, in turn, submits to CMS, Provider certifies, to the best of its knowledge and belief, that such data is accurate, complete and truthful. Provider agrees to cooperate with and participate in internal and external review procedures necessary to allow Company to process Medicare appeals and grievances in accordance with Medicare laws, regulations and CMS instructions.

C. Federal Fund Obligations. Provider understands and agrees that payments received by Company for the Medicare Plans from CMS pursuant to the Medicare Plan's contract with CMS are Federal funds. As a result, Provider, by entering into this Agreement and the terms of this Addendum, is subject to laws applicable to individuals/entities receiving Federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R. part 84, the Age Discrimination Act of 1975 as implemented by regulations at 45 C.F.R. part 91, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

D. Continuation of Services. In the event Company's Medicare contract for the Medicare Plans with CMS terminates or Company becomes insolvent, Provider shall continue to provide Covered Services to Medicare Members who are hospitalized through the later of: (a) the date for which premiums were paid, or (b) through the date of discharge. Provider is prohibited by law from billing Medicare Members for such Covered Services. This provision shall survive the termination of this Agreement or Addendum, regardless of the reason for termination, including the insolvency of Company, and shall supersede any oral or written agreement between Provider and a Medicare Member.

E. Policies, Programs & Procedures. Provider agrees to comply with Company's policies and procedures (which Company shall provide to Provider upon request) which operationalize many of the requirements of the Agreement, this Addendum, and the Medicare Program. Provider agrees to comply with Company's quality improvement, administrative processes and procedures, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures, and any other policies Company may implement, including amendments made to the above mentioned policies, procedures and programs from time to time. In the event that a Company policy or procedure conflicts with a provision in the Agreement, then the language in the Agreement (including all amendments, exhibits, and attachments thereto) shall govern.

F. Maintenance of Records. Provider shall preserve records applicable to Medicare Members or to Company's participation in the Medicare Program, for the longer of: (i) the period of time required by State and Federal law, or (ii) ten (10) years, whichever is longer. In addition, to the extent applicable to Provider, Provider, on behalf of itself and any Downstream Entities with whom Provider has contracted, agrees to comply with 42 C.F.R. §422.2480(c)

and to maintain all records containing data used by Company to calculate Medicare medical loss ratios ("MLRs") for Company's Medicare Products and/or evidence needed by Company and/or federal governmental authorities with jurisdiction to validate MLRs (collectively, "MLR Records") for a minimum of ten (10) years from the date such MLRs were reported by Company to CMS.

G. Subcontractors. Provider shall require all of its subcontractors, if any, to comply with all applicable Medicare laws, regulations and CMS instructions.

(1) Provider shall include in Provider's contracts with subcontractors all of the contractual and legal obligations required by Company or the laws, regulations, rules and directions of CMS, including, without limitation, that any delegated services or activities to be performed by subcontractor shall be consistent and comply with the obligations in the contract between CMS and Company governing Company's participation in the Medicare Program. To the extent CMS requires additional provisions to be included in such subcontracts, Provider shall amend its contracts accordingly.

(2) Provider shall ensure that any vendors, subcontractors or other such entities that have a need to know the terms of the Agreement also maintain the privacy and confidentiality of all financial terms of the Agreement.

(3) If Provider arranges for the provision of Covered Services from other health care providers for Medicare Members, such contracts shall be in writing and shall specify the delegated activities and reporting responsibilities, in addition to meeting the requirements described above. In the event that Company delegates to Provider the selection of providers, Company retains the right to approve, suspend or terminate such delegation. If Company delegates the selection of providers, Company will either review the credentials of medical professionals affiliated with Provider or Company will review, approve, and audit on an ongoing basis Provider's credentialing process. The term "Subcontractor" as used in this Section shall not refer to employees or other individuals that perform services on behalf of Provider for which Provider bills such services under this Agreement. Provider represents and warrants that such persons are subject to all terms and conditions of this Agreement and Provider shall provide written evidence of such as described in the Agreement.

H. Contracts with Excluded Entities. Provider understands and agrees that no person that provides health care services under this Agreement, or persons that provide utilization review, medical social work or administrative services in support of services billed under this Agreement by Provider may be an individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. Provider hereby certifies that no such excluded person will provide such services under this Agreement and no such excluded persons will be employed by or utilized by any Downstream Entity with which Provider contracts relating to the furnishing of these services to Medicare Members. In accordance with applicable laws, rules and regulations and the Compliance Program Guidelines, Provider agrees to review the Department of Health and Human Services ("HHS") Office of Inspector General List of Excluded Individuals and Entities and the General Service Administrative Excluded Parties Lists System (collectively, "Exclusion Lists") to ensure that Provider Related Parties are not included on such Exclusion Lists. Provider agrees to review the Exclusion Lists prior to initially hiring, appointing or contracting with any new Provider Related Party and at least once per month thereafter to confirm that Provider Related Parties are not included on such Exclusion Lists. Provider agrees that if a Provider Related Party appears on an Exclusion List and/or is excluded from participation in any federally-funded health program, Provider will immediately remove the Provider Related Party from any work related directly or indirectly to Company's Medicare Plans, and take all corrective actions required under applicable laws, rules or regulations. In the event Provider or any Provider Related Parties are listed in an Exclusion List after the Effective Date of this Addendum, Company shall have the right, in its sole discretion and judgment, to terminate this Addendum in accordance with the Agreement or to disqualify the listed person(s) from providing any part of the Covered Services. For the purpose of this section "Provider Related Parties" means Provider's permanent and temporary employees and Downstream Entities that are involved in the performance of Medicare Services.

I. Offshore Services. Provider is prohibited from using any individual or entity ("Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative or other individual or entity) to perform any services for Medicare Plans if the individual or entity is physically located outside of one of the fifty

United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands) ("Offshore Services"), unless Company, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity. Provider further agrees that Company has the right to audit any Offshore Entity prior to the provision of Offshore Services for Medicare Plans. Additionally, Provider acknowledges and agrees that Offshore Services that involve Medicare Member protected health information (PHI) are subject to CMS reporting within thirty (30) days of: (1) performing, or contracting with an Offshore Entity to perform, Offshore Services, and (2) any time Provider changes the Offshore Services that an Offshore Entity will perform.

J. Submission of Encounter Data. Provider hereby acknowledges that Company is required to provide CMS and other federal and state regulatory agencies and accrediting organizations with encounter data as requested by such agencies and organizations. Such data may include medical records and all other data necessary to characterize each encounter between Provider and a Medicare Member. Provider agrees to cooperate with Company and to provide Company with all such information in such form and manner as requested by Company. Provider agrees to immediately notify Company if any encounter data that Provider submitted to Company for Medicare Members is inaccurate, incomplete or erroneous, and cooperate with Company to correct erroneous encounter data to ensure Company's compliance with Medicare laws, rules and regulations and CMS instructions.

K. Certification of Data. Provider recognizes that as a Medicare Advantage organization, Company is required to certify the accuracy, completeness and truthfulness of data that CMS requests. Such data include encounter data, payment data, and any other information provided to Company by its contractors and subcontractors. Provider and its subcontractors, if any, hereby certify that any such data submitted to Company will be accurate, complete and truthful. Upon request, Provider shall make such certification in the form and manner prescribed by Company.

L. Medicare Member Complaints. Provider agrees to cooperate with Company in resolving any Medicare Member complaints related to coverage for the provision of Covered Services. Company will notify Provider as necessary concerning all Medicare Member complaints involving Provider. Provider shall, in accordance with the Provider's regular procedures, investigate such complaints and respond to Company in the required time. Provider shall use best efforts to resolve complaints in a fair and equitable manner.

M. Compliance Program and Anti-Fraud Initiatives. Provider shall (and shall cause its subcontractors to) institute, operate, and maintain an effective compliance program to detect, correct and prevent the incidence of non-compliance with CMS requirements and the incidence of fraud, waste and abuse (FWA) relating to the operation of Company's Medicare Program. Such compliance program shall be appropriate to Provider's or subcontractor's organization and operations and shall include: (a) written policies, procedures and standards of conduct articulating the entity's commitment to comply with federal and state laws, as well as providing mechanisms for employee/subcontractor use in adhering to the expectation that Provider and employee/subcontractor report potential non-compliance or FWA issues (internally and to Company, as applicable); (b) for all officers, directors, employees, contractors and agents of Provider or subcontractor, required participation in effective compliance and anti-fraud training and education that is consistent with guidance that CMS has or may issue with respect to compliance and anti-fraud and abuse initiatives, unless exempt from such training under relevant CMS regulations. This includes general compliance and FWA training completion, as well as code of conduct dissemination, initially within ninety (90) days of hire/contracting and at least annually thereafter; Provider and subcontractors, as applicable, may use Company's code and training or an equivalent; and (c) processes to oversee subcontractors to ensure their compliance with these requirements.

N. Marketing. Consistent with Federal laws, regulations, and agency requirements applicable to the Medicare Advantage Program, Provider shall not: (1) engage in any marketing or sales activities that could mislead or confuse Medicare beneficiaries, or (2) market or advertise non-health care related products to Medicare Members or prospective Medicare Members. Further, Provider shall at all times comply with the then current Medicare Marketing Guidelines.

O. Dual-Eligible Hold Harmless. Provider acknowledges and agrees that Medicare Members who are also enrolled in a State Medicaid plan ("Dual Eligible Members") are not responsible for paying to Provider any Copayments, Coinsurance or Deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when the State Medicaid plan is responsible for paying such Cost Sharing Amounts. Provider further agrees that they will

not collect Cost Sharing Amounts from Dual Eligible Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the Company's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts, or bill the applicable State Medicaid plan for the appropriate Cost Sharing Amounts owed by the State Medicaid plan.

7. COMPANY OBLIGATIONS.
A. Fee Schedule. Company shall arrange for Provider to be compensated for health care services rendered to Medicare Members in accordance with Section 2 of this Addendum.

B. Prompt Pay. In accordance with 42 C.F.R. § 422.520(a)(1), Company shall make best efforts to pay clean claims submitted by Provider for Covered Services provided to Medicare Members within thirty (30) calendar days of receipt. For purposes of this Addendum, the term "clean claim" shall have the meaning assigned in 42 C.F.R. §422.500.

8. GENERAL PROVISIONS
A. Termination. This Addendum may be terminated on its own without respect to the remainder of the Agreement with or without cause by either Party in accordance with the termination provisions of the underlying Agreement. This Addendum shall terminate automatically in the event that the underlying Agreement is terminated in accordance with the termination provisions of the Agreement.

B. Governing Law. This Addendum shall be governed by Federal laws, regulations, and agency requirements applicable to the Medicare Advantage Program. In the event that changes to the governing laws, regulations, or agency requirements applicable to the Medicare Advantage Program occur, the new law, regulation or agency requirement shall supersede to the extent required by any such later required changes.

C. All other terms and provisions of the Agreement not amended hereby shall remain in full force and effect, without modification. In the event of any inconsistency between the terms of this Addendum and the Agreement, the terms of this Addendum shall govern and control.

D. Survival. All provisions of this Addendum which by their nature should survive termination of Provider's provision of Medicare Services under this Agreement or termination of the Agreement as a whole, shall survive termination.

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Schedule 1

Medicare Required Provisions

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement between Company and Provider (referred to in this Schedule 1 as "FDR") not inconsistent herein shall remain in full force and effect. This Exhibit shall supersede and replace any inconsistent provisions to such Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

NOW, THEREFORE, the parties agree as follows:

A. Definitions:

1. Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

2. Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

3. Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

4. Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

5. First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

6. Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

7. Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

8. Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

9. Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

10. Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

B. <u>Required Provisions</u>:

FDR agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with Company's Affiliates included in this Agreement, (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)] and [42 CFR §423.505]

2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph 1 of this amendment directly from any first tier, downstream, or related entity. For records subject to review under paragraph 1, except in exceptional circumstances, CMS will provide notification to the MA organization that a direct request for information has been initiated. [42 C.F.R. §§ 422.504(i)(2)(ii) and (iii)]

3. FDR will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118] and [42 CFR §423.136]

4. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)] and [42 CFR §423.505(i)(3)(i)]

5. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. FDR may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

6. Any services or other activity performed in accordance with a contract or written agreement by FDR are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)] and [42 CFR §423.505(i)(3)(iii)]

7. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between the MA Organization/Physician and the provider. [42 C.F.R. §§ 422.520(b)(1) and (2)]
   See Section 7.b of the Addendum to which this Schedule 1 is attached.

8. FDR and any related entity, contractor or subcontractor will comply with all applicable Federal and Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)] and [42 CFR §423.505(i)(4)(iv)]

9. If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity:

[INFORMATIONAL NOTE: If there is no delegation of a specific activity or responsibility, please delete the related provision and replace with "None delegated".]

(i) The delegated activities and reporting responsibilities are specified as follows:

[List activities and reporting responsibilities or enter the section and name of the delegation or applicable agreement].

(ii) CMS and the MA organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.

(iii) The MA organization will monitor the performance of the parties on an ongoing basis.

[Enter any applicable section and name of the delegation or applicable agreement].

(iv) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.

[**Enter any applicable section and name of the delegation or applicable agreement].**

(v) If the MA organization delegates the selection of providers, contractors, or subcontractor, the MA organization retains the right to approve, suspend, or terminate any such arrangement.

[42 C.F.R. §§ 422.504(i)(4) and (5)]

In the event of a conflict between the terms and conditions above and the terms of a related agreement, the terms above control.